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A REPORT*

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I feel deeply honored to be the presiding officer of the Medical Society of Virginia at this, the 100th meeting. This Medical Society was organized in 1821. The first president was Dr. James McClurg, of Richmond. Due to causes undetermined, there were several intervals of a few years each when no meetings were held. In 1870, following the War Between the States, the Society was re-organized and has held annual meetings since that year.

Following this brief address you will hear two distinguished men who will speak on the progress that medical science has made in Virginia and the United States in the past hundred years. For my part, I wish to report a few things that have interested the members of the Medical Society of Virginia during the past year.

President Truman has sent several messages to the Congress advocating compulsory medical care, financed by taxes and under strict Federal administration. There is strong evidence that these ideas were initiated and propelled by members of the Federal agencies. The Federal employees have established what they call "Health Workshops" in various locations. Allow me to quote from the last report of the Congressional Committee on Expenditures in the Executive Departments: "All the evidence before your committee indicates that these health workshops were planned, conducted, and largely financed with Federal funds, by a key group on the Government pay roll, who used the workshop method of discussion subtly to generate public sentiment in behalf of what certain witnesses and authors of propaganda refer to as socialized medicine. It is evident from the record that most of the planning was done by the Federal officials in Washington prior to each workshop conference and that each meeting was devoted to their own purposes—that of organizing pressure groups to agitate for compulsory health insurance, as then pending in Congress." In the concluding paragraph of their report they make this statement: "Suffice it at this time for your committee to report its firm conclusion, on the basis of the evidence at hand, that American communism holds this program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow-travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard."

Our political history shows that, whenever there are available large sums of government money, political influence and patronage thrive. Of course, compulsory medicine would necessitate the formation of other political bureaus. We all know how we have suffered in the recent past from bureaucracy. This would only add to our burden. The kind of medical care which the President advocates would involve the payment for medical services by a third party, which would disturb very seriously the patient-physician relationship. The patient is tempted to demand more attention than required and the temptation to some physicians to render unnecessary medical service would be great, as his income would depend upon the volume of his business. The fact that most physicians have as much as they can do at present, the added burden of rendering unnecessary care, and the making of reports in triplicate or quadruplicate to the Government agencies would make it humanly impossible to give the proper study to this increased volume of patients.

Socialized medicine originated in Germany about 1880 and was initiated in England a few years ago. This has resulted in marked deterioration of the quality and the quantity of medical care rendered. We all recognize the large part played in the maintenance of good health by proper housing,

*Address of the President, Medical Society of Virginia, before the annual meeting at Roanoke, October 13-15, 1947.

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clothing, food and sanitation. None of this would be improved by any of the bills so far introduced in the Legislative bodies in the United States.

About 5% of the members of the medical profession do have a tendencey to charge exorbitant fees, and I feel that this has had something to do with initiating proposals for the introduction of compulsory medical care in this country. The medical profession as a whole is always willing to do what it can to relieve individuals of the expense of catastrophic illnesses, and it was with this idea in mind that prepaid hospital care in non-profit organizations was initiated. It is stated that at least 30 million have this care in the Blue Cross and it is variously estimated that an additional 15 to 20 million have taken out this protection through commercial companies. Within the last four years prepayment medical care has been introduced by the physicians. There are over sixty such plans in the United States operated on a non-profit basis at the present time. The membership of these organizations is over 6 million and increasing at the rate of over 200,000 a month, with over 140,000 in Virginia at present. This protection is also carried by many thousands in commercial companies. The fees that are paid for services rendered in these organizations, especially for surgical work, are possibly a little bit below the normal fees for the same type of work in a great many communities, but the condition equalizes itself, as the physician obtains fees from persons who would be unable to pay anything without this protection. And it is the duty of every physician to cooperate fully with these different plans, in order that we may combat, as far as possible, the urge for socialized medicine.

There has been considerable difficulty in persuading the rural population to take out this protection, but progress is being made with different groups of various farm organizations.

We hear a great deal about inadequate medical care and it is undoubtedly true that there are certain areas in the state of Virginia, as well as every other state, which do have inadequate care. This is chiefly in the rural areas, which are sparsely settled and under ordinary circumstances would not be able to support a physician.

The Hill-Burton Bill, which has recently been passed by our national Congress, provides a certain sum of money each year for the next five years to help overcome this deficiency. The Commissioner of Health has just completed a survey of Virginia in which certain areas have been designated as base hospital areas. They are Norfolk, Richmond, Charlottesville and Roanoke. Back of these are the smaller hospitals, which are called regional hospitals, and in the rural communities will be established what are known as health centers. The type of health center has not been definitely determined in Virginia, but it seems to me that a building could provide eight or ten beds for obstetrical and emergency cases and offices for the health officer of the community who would give preventive inoculations and look after the sanitation of his area. A laboratory and an x-ray technician should also be provided whose reports would be transmitted to the physician in charge, to assist him in making a proper diagnosis. Having these facilities would encourage younger men to go into rural communities to carry on the work of their profession. Good roads would also increase the area which could be served by these health centers. Illnesses which can not be handled by the health centers would be transferred to a regional hospital, and if proper treatment could not be rendered in these institutions they would be sent on to a base hospital area.

This Hill-Burton Bill provides in Virginia, in the form of State aid, the sum of over $2,000,000 a year for the five-year period. The locations for additional beds and health centers recommended by the office of the Commissioner of Health as a result of the surveys would have to be confirmed by the Surgeon General's office of the Public Health Service before construction could be initiated. This bill also provides that two-thirds of the cost of construction is to be borne by the community and one-third would come from Federal funds, provided that it is shown that the special community in which these health centers are located can support them. In certain rural communities which can not raise two-thirds of the money required for this construction it is undoubtedly the duty of the State to provide their proportion. I want it thoroughly understood that after the location has been approved there will be absolutely no Federal control.

The great difficulty would be in staffing these hospitals. The first requirement is a well-qualified general practitioner, who is often spoken of as the "forgotten man". A great tendency in our present

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age is specialization. In a recent survey made in Virginia our central office in Richmond sent out 1,921 postal cards to obtain information as to how many specialists and how many general practitioners we have in the state. 66.4% of these cards were returned, with the result that they showed 43.3% general practitioners, with an average age of 52, and 56.7% specialists. When you consider the fact that a well qualified general practitioner can look after 85% of the patients seen and will call in the proper specialist for assistance and advice concerning the other 15% it leads you to believe that, if the present tendency continues, a great many of the specialists will revert to general practice in order to make both ends meet. Probably the cause of this tendency to specialize may have a financial basis. A great many men who are returning from the Services have seen the increased rank given to specialists. I feel that the teaching institutions have a great deal to do with this tendency among the students. They are lectured to by specialists in each line. On graduation and application for internship in most of the larger hospitals they must designate whether they will be in medicine or surgery. At their age they are incapable of choosing and they stay through the first year in the course designated. It is stated that they are advised to take an additional year on the other services, but very few of them do. Would it not be better for the physician and the ultimate patient if they were given at least two years of rotating internship? They would then be in a better position to determine which specialty they are particularly fitted for and, if they do not specialize, they would be better qualified for the general practice of medicine. Those who elect to go into general practice should be encouraged to keep up with the advances made in medical science. I feel that it is the duty of the Medical Society of Virginia to hold post-graduate courses in the teaching hospitals and to send out teams to the rural communities to instruct those unable to attend the regular courses. This is being done, to some extent, by The Department of Clinical and Medical Education of this Society in the early diagnosis of cancer. A great many of our larger hospitals have only specialists on their staff. There are a few more progressive hospitals at present which are putting a general practice section on their staff. I am glad to see that the American Medical Association has designated a general practice section, and I am also glad to know that the members of the Medical Society of Virginia are attempting to form such a division.

The increased demand for nurses by the Army and Navy, the Public Health Service, industry and other branches has resulted in a serious condition as to the supply of nurses. The increased educational requirements for entrance in training schools and the amount of time spent in didactic teaching has brought about a change in the method of nursing, which I do not believe is beneficial to the patient, either from a financial or nursing point of view. There are at present three hospitals in Virginia which have initiated a training school for practical nurses, giving a course of one year in all the essentials for bed-side nursing. At the end of this period, by taking the examination, they become registered practical nurses. These should be qualified to perform most of the duties required in bed-side nursing care in the home or hospital.

The Medical Society of Virginia at its last session confirmed the action of the Council in establishing a Department of Public Relations, which has been doing splendid work. The development and maintenance of good will is the fundamental objective of the profession in public relations. Physicians are individualists who do not as a rule spend much time telling the public how good they are or how much good they do. We have a competent Director of Public Relations who will tell the public but whose chief job at present is to educate the profession along these lines. We have asked every component society to appoint a Public Relations Committee who will have charge of this phase of the work in their particular community. This has been done in most local societies. The next thing necessary is a little needling to make them function. The radio and press have been used in educating the profession and the public as to what the profession is doing, and efforts have been made to impress upon the public the importance of protecting themselves against catastrophic illnesses by participation in the prepayment hospital and medical care plans.

The medical profession is the only profession which exerts so much effort in every way to put themselves out of business. In comparatively recent years by research they have found that proper

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sanitary regulations lessen the amount of sickness. They have developed preventive inoculations against certain diseases and are constantly working to develop others. They have found that some diseases can be modified or cured by antitoxins. It has been their constant desire to protect citizens as far as possible.

They also want to protect the population against the practice of members of certain cults who do not believe in preventive inoculations, antitoxins, insulin for diabetes, or any of the recognized measures used for the prevention and the alleviation of certain conditions. The sole belief of these cultists is that all pathological conditions are due to some malalignment of the vertebrae. In opposing these practices the sole object of the medical profession is to protect the public. We see too many patients who have spent too much time being "adjusted", and, when they come under the care of a physician, are found to have cancer, tuberculosis, or one of the many other conditions which, if taken early, could have been benefited or cured.

A law passed in 1944 required these practitioners to take an examination on basic sciences and make a passing grade of only 50%. Certainly, any one who pretends to diagnose or treat the sick should have the elementary knowledge which these subjects include. According to this law they have been given five years in which to prepare themselves for this basic examination. So far none has applied. Of course, if the majority of the population and the representatives in the State Legislature want these people without proper education to diagnose and treat their diseases, the medical profession, who see so many distressing results, will say nothing more. I would like to repeat—we only wish to protect the public. The Legislative Committee and our attorney have gotten out a pamphlet giving the history of the cultists. If the Legislators would read these true facts and act conscientiously the public would be protected.

We now come to the consideration of that class of chronically ill who are unable to pay for any medical care. They are the responsibility of their communities and the state, and up to the present have been provided for very inadequately. I am glad to see that we are making some progress for their better care. I believe that the Council on Health and Medical Care is greatly responsible for calling the attention of the Legislature and the Executive to the conditions as they exist. The Legislature in 1946 passed a law, referred to as the State and Local Hospitalization Program for Indigents, amended at the Special Session in 1947, which "made available the sum of $600,000 each year of the current biennium to be used on a matching basis by the counties and cities of the Commonwealth for the hospitalization of indigent and medically indigent persons residing within the State boundaries. $300,000 is in the form of established credit in the amount of $150,000 at each of the hospital divisions of the University of Virginia and the Medical College of Virginia. . . . . The eligibility of individuals for hospitalization under this program is determined solely by the locality". The law specifically states, however that "this program is not limited to those individuals who are eligible for public relief but also the program includes the group often referred to as medical indigents." The Governor has allocated a special fund for increasing the physical plants and the personnel in the state institutions to enable them to give these poor unfortunates proper care and treatment. The medical profession has always devoted much time to the care of the indigent and will always be glad to do this.

I hope you have gathered from this report:

1. That the members of the Medical Society of Virginia are opposed to compulsory bureaucratic medical care, as it has been proven in other countries to result in deterioration in the quality and the quantity of medical care;

2. That we feel that voluntary prepayment hospital and medical care is far superior to any form of compulsion;

3. That it is our sole aim to protect the public from any form of practice which is not founded on scientific facts;

4. That any funds contributed by the Federal Government for the care of the sick should be in the form of State aid and be controlled by the proper department of the State Government.

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SURGICAL MANAGEMENT OF UNILATERAL HARELIP*

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In frequency, no other congenital abnormality occurs more universally than that of the cleft lip. No race is exempt and some writers have placed its presence as one in every two thousand births. Because of its common occurrence in the past, almost every physician doing surgery has tried his hand at closing the deformity. I say "closing" because it was for the most part their only aim, and the patient was left with much to be desired as to satisfactory cosmetic and physiological results. In this communique, I will present some of the advances made in recent years by investigators in this field.

The repair of unilateral harelips has developed from that of obtaining a simple union of the cleft to a scientific reconstruction which affects not only the closure but also produces a satisfactory function and a good cosmetic result.

The first operation performed on the harelip dates back to 42 B.C. At that time methods were devised to obtain closure of the lip by denuding the edges of the cleft and suturing them together. Almost no concept of future development entered into the operative plan, with the result that postoperative deformities occurred frequently and the stigma of the affliction was borne by the patient for the remainder of his life. Whereas satisfactory function can be obtained by this crude method, it leaves much to be desired in the way of cosmetic perfection.

Such men as LaMonier in 1794, Grabe in 1817, John Warren in 1820, and VonLangenbeck in 1861 devised various types of procedures with the object of obtaining a more perfect closure. They proved, by their varied technics, the unsatisfactory results that were then obtained generally. Very few of these methods took into consideration the differences in anatomical relationships of the deformed side with that of the normal lip. It remained for Mirault in the latter part of the 19th century to approach this problem with any degree of scientific investigation or consideration. His technic did much to overcome the postoperative deformity of shortening of the lip and the malformation of the involved nostril. This operation, which was modified to some extent by Blair in the early part of the 20th century, is today the best procedure.

The etiology of harelips, in spite of the widespread investigation during the last twenty to thirty years, still remains shrouded in considerable uncertainty. Various theories have been advanced, such as the formation of adhesive bands within the facial clefts about the sixth week of fetal life at which time these clefts ordinarily close, maternal impressions, damage of the ova, and heredity. All theories have been sustained with some degree of proof; however, as we look at the problem today, heredity probably has the most impressive support. In reviewing data collected by various investigators as to the role it plays in this deformity, one cannot help but be impressed by the fact that in most instances a definite history can be obtained where members of the child's ancestry have had either a cleft of the lip or of the palate or both. Approximately twenty-five per cent fall into this group. This percentage would probably be larger if more families were certain of their background. In spite of the evidence brought forward by these statistics, there are certain other interesting features occurring in the incidence of these cases that cannot be ignored. The majority of children with harelip deformities are born to parents in their early twenties and it usually occurs in the first male offspring. The intermarriage of closely related families seems to increase its frequency. If such defects occur in one child, there is only a ten per cent chance that other children of the same marriage will have a harelip, unless either the mother or the father has a cleft lip or palate. The incidence and type of this deformity have been studied with the results we find that males are afflicted in 52.6%, females 47.4%, unilateral cleft of the right side of the lip 40%, and unilateral cleft of the left 60%. Statistics show that 16.5% of harelip cases also have an enlarged thymus gland, while 19.8% of these cases have other associated congenital abnormalities.

It is imperative in the repair of these cases that the anatomy involved is taken into minute consid-

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eration. The normal upper lip consists of definite contour with which we are familiar. This is supported by the orbicularis oris which surrounds the entire mouth and consists of many interlacing bundles of muscle. This muscle, also is closely associated with fibers of the triangularis, the canius, the risorius, the zygomaticus and the buccinator. Because of this association, when the muscle is divided, as it is in single harelip, the lateral half is pulled upward and outward by the buccinator muscle. The medial portion, having less support, is usually under developed and is retracted toward the columella. Section through the divided portion of the orbicularis oris reveals an absence of the horizontal fasciculi in the area of the cleft. This may result in an abnormal contraction even in the most perfect closure. The amount of mucous membrane forming the under surface of the lip and the vermilion border is always decreased. This is due primarily to under development of the overlying structures. The above facts bring to attention the necessity of obtaining as much lip area in the region of the cleft as is possible for a satisfactory length, thickness and width of the portion to be closed. Needless to say, none of the available material should be sacrificed unnecessarily.

In order to obtain the highest degree of operability, preoperative preparation of these individuals should be carried out with the utmost thoroughness. Harelips have been repaired from the age of two hours up until adult life. A lot of discussion has been given to the most opportune time for reconstruction. Today, whereas some surgeons prefer the first week, the majority think it wisest to wait until the child is at least six to eight weeks of age. By this time, it is usually accustomed to being artificially fed, is able to take nourishment reasonably well, and has shown either satisfactory or unsatisfactory progress in growth and development, and other congenital defects, if present, should be in evidence at this age. No other operation should be undertaken at the time the lip is repaired, as this is a major procedure and one should not jeopardize the outcome in his eagerness to repair other deformities. These patients should be admitted to the hospital for at least forty-eight to seventy-two hours prior to operation. This allows the child to become acclimated to hospital routine and to afford the attending surgeon an opportunity to make two or more complete physical examinations. A thorough history is taken, including the presence or absence of congenital deformities in the immediate family, the health of both the mother and father and contact of the baby with contagious diseases, particularly tuberculosis. Laboratory studies including blood and urine examinations are made as well as x-rays to determine the presence or absence of chest pathology, and particularly enlargement of the thymus gland. If the hemoglobin is below 75%, a transfusion is given before operation and, if it is over 75%, provisions for donors are made in case they are needed following the repair. The clotting and coagulation times are determined and, unless these tests are normal, the operation is postponed. In cases giving a history of jaundice following birth, the administration of vitamin K is indicated. When the child is accepting the milk formula satisfactorily, the administration of calcium is not necessary. It is essential that the urinary output be estimated and if there is some question as to kidney function, the operation is delayed until the possibility of congenital deformities in these organs has been ruled out. All temperatures are obtained rectally every four hours and when there is an elevation above 99, the cause of this fever is eliminated before operation. The ears, nose and mouth are examined daily since the majority of these patients carry residual infections particularly in the nasal cavities. If discharge from the nose is more than normal, smears are taken to determine the nature of bacterial activity. In the past, preoperatively, nose drops of ephedrine, neosynephrine or 5% sulfathiazole suspension have been used. These have been recently discontinued because in occasional cases they have caused vomiting on administration and the therapeutic efficacy is questionable unless actual infection is found. The examination of the heart and lungs is of the utmost importance and daily checks for pathology in these organs is advisable. Much can be gained by watching the general behavior of these patients. Frequently, general examinations do not show muscular weakness, presence of convulsive seizures, or lethargic states. Needless to say, operative repair of patients showing any of the latter conditions, would be untimely.

Following the determination of the patient's operability, the surgeon proceeds with the plan of operation. To simplify this matter, it is better to consider

the three types of deformity that occur in single harelips. The simplest is a cleft of the vermilion edge of the lip extending up for a distance of usually one-half to one cm. toward the nostril floor. This is stage one. In stage two, there is an extension of the cleft up to and including the nostril floor but is not associated with a cleft of the alveolar ridge. In stage three, we find a complete cleft of the entire lip and nostril floor associated with a deformity of the alveolar ridge and palate. The nose, the vermilion edge and the lip are considered separately in outlining the procedure.

In stage one, the nose is usually normal or only slightly flared (Fig. I a and b; Fig. II a and b).

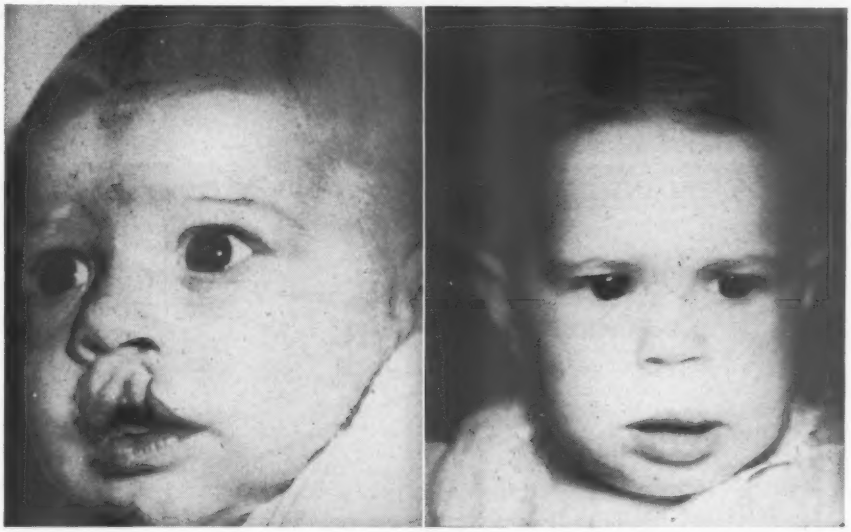

Fig. I—(a) Stage one harelip showing underdevelopment of both edges of the cleft. (b) Results obtained following repair by the Modified Blair Mirault technic.

Fig. II—(a) Stage one harelip with flaring of the nostril on the involved side. (b) Postoperative results obtained following procedure described in the text. The deformed nostril was made equal to that of the normal side because no future widening is anticipated.

Here it is best to complete the cleft into the floor of the nostril and to measure accurately the width of the normal side so that at this first operation the affected side can be constructed accordingly. Consideration of the height of the nostril is not a serious problem in these cases, as the future growth of the lower lateral cartilage will usually equalize the two nostrils.

In stage two, as in stage one, there is enough tissue to construct a normal floor which can be expected to remain fixed as development takes place (Fig. III a and b). However, we have another problem of a wider rotated ala with flattening of the lower lateral cartilage which can be corrected by making incisions within the nostril at the upper and lower edges of the cartilage and dissecting it free. Following this, the entire lateral portion can be removed from the nose and the angle of required height can be determined. This is then sutured to the angle of the normal side of the nose. The above procedure not only establishes height but does away with the buckling of the cartilage in the center of the nostril edge.

Fig. III—(a) Stage two harelip with excessive widening of the nostril in a child eight years of age. (b) The repair shows equal nostrils and normal lip thickness and length.

In stage three, there are two additional problems, rotation of the ala and lack of tissue for an adequate nostril floor (Fig. IV a and b and Fig. V a and b). The latter is further complicated by the fact that there is no foundation for the floor to rest upon. Future growth will destroy the most perfectly constructed nostril and, therefore, unsightly allowances may have to be made to take care of later development. For relaxation, the tissue of both cheeks is extensively undermined. The floor of the nostril is made from a full thickness lip flap taken from the upper lateral side of the cleft. This is anchored to the septum and when the ala edge is sutured to it, the width of the nostril should be the same size or smaller than that of the normal side. Care is taken to allow for internal rotation of the ala. This must also be raised slightly to make allowances for the future downward pull of the lip scar and dental development. The lower lateral cartilage can be readjusted as in stage two.

The construction of the lip is now considered. This includes the thickness, length and fullness of the lower one-third.

In the first stage, the cleft is usually narrow and the two sides are about equally developed. Muscle development is good and so thickness is not a real problem. In the majority of cases, simple excision of the vermilion edge of the cleft and correct approximation of the wound produce a satisfactory result.

In the second stage, measurements of the normal side are taken first. The width of the floor of the nostril is measured between the lateral edge of the

columella and the inner lower border of the ala. The distance from the columella to the vermilion edge and from the ala to the vermilion edge are ascertained. The corresponding points are determined on the defective side. This determines the length of the lip and width of the nostril floor. It will be noted that if the thinned out edges of the cleft are sacrificed, the thickness of the lip will be sufficient as the line unavoidably passes through normal muscle development. The fullness of the

Fig. IV—(a) Stage three harelip with rotation of the medial side of the alveolar process into the floor of the nostril and deviation of the columellar to the normal side. (b) The normal size of the nostril, as shown above, was obtained by dividing the septum at the base and shifting it to the midline. The line of incision was carried through the normal lip tissue in order to secure adequate length and thickness of the entire lip.

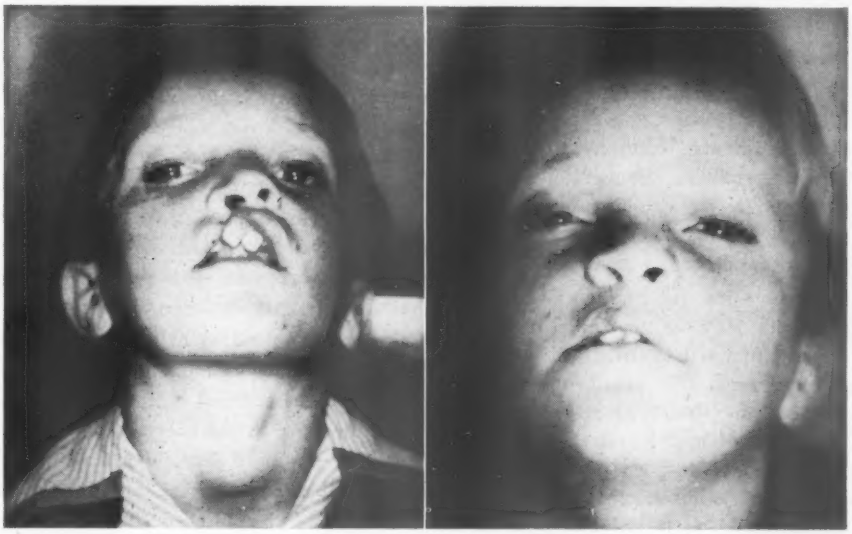

Fig. V—(a) Stage three harelip with rotation of the alveolar process into the floor of the right nostril and underdevelopment of the lip on both sides of the cleft in a boy ten years of age. (b) A satisfactory repair was secured after shifting the columellar to the midline and forming the floor of the nostril with a pedicle flap taken from the upper medial portion of the cleft.

lower border is obtained by measuring the perpendicular distances from the first line on the lateral side to the fullest vermilion edge of the cleft on that side. The lower triangle so formed, assures an increase in fullness by one-eighth to one-fourth inch in this area. It is wise to allow a little increase in length on the affected side when the patient is young and when the lower part of the cleft is excessively wide.

In the third stage, in addition to problems presented in stage two, a flap for the floor of the nostril is outlined. This is done by turning inward one-fourth to one-half cm. of the upper lateral edge of the skin, the inner edge of which is medial to the line drawn from the ala to the vermilion border. The width of this must be included in the nostril floor measurements.

Plans for vermilion border should include thickness, accurate approximation of skin, vermilion line edge, and minimization of scar contraction which may produce puckering.

In all stages the problems are the same. If the lip measurements are taken to match the normal side, thickness is not a real problem. Skill in matching vermilion skin edge alignment is the only prerequisite to this solution. Reduction of excessive scar contraction is best carried out by notching the vermilion border in the tongue and groove fashion. This not only breaks up a continuous suture line, but gives a more rounded appearance to the lip.

Pre-operatively, the patient is allowed nothing by mouth for six to eight hours. No hypnotic drugs are administered to infants; however, in older patients morphine is given. The infants receive 1/750 grain of atropine and the older children larger doses. The lower bowel is emptied eight hours before the patient is taken to the operating room.

At operation, the arms are tied down and the skin is cleaned with 70% solution of alcohol, all crusts are removed from both nostrils, and the head is draped in sterile towels. The anesthetic of choice is open ether spray and should never be sufficient in amount to produce complete relaxation. It is better to have the child slightly tense and not to destroy the gag reflex too completely. If deeper anesthetic is administered, there is always danger that laryngeal spasm or aspiration of material into the trachea may occur. Continued suction of the oral cavity with a catheter or metal tube is used throughout the entire operative procedure. Measurements of the normal side are taken and fixed on the affected side by small puncture wounds in the skin with sterile calipers. The first step is to undermine thoroughly the entire lip, cheek, the lateral portion of the nose up to the infra-orbital region and as far laterally as is necessary to gain complete relaxation of the lateral half of the face. Care is taken to preserve the infra-orbital vessels and nerves, as cutting these does not increase relaxation and may establish numbness and deficient blood supply in this area. The medial side is undermined as far as one centimeter to one and one-half centimeters beyond the normal ala. The descending portions of the lower lateral cartilages in their apposition with the tissues at the base of the columella are preserved. Occasionally, if there is a wide deviation of the columella, it may be necessary to make a submucous incision at the base of the septum in order to shift this structure to the midline. All bleeding is controlled with fine hemostats and packing. The lip incisions are made between previously measured points on each side and include the skin, muscles, and mucous membrane. These are carried to the vermilion border on both sides of the cleft, but they do not include it, as it is impossible to determine the required amount that is to be needed at this stage. The skin over the lower lateral cartilage on the affected side is elevated with a pair of small scissors so that the cartilage can be easily rotated into its new position without buckling. In some instances, it is necessary to dissect the entire lateral half of the cartilage free in order to raise the angle to that of the normal side. The floor of the nostril is formed by suturing the muscles of the lateral half of the lip to the connective tissue at the base of the columella with an inverted 000 chromic catgut suture. It is very important to place this accurately, as it forms the foundation of the nostril which should be at the same level and circumference as that of the normal side. This brings the ala on the affected side upward and inward. The suturing of the muscles and mucous membrane is further continued from above downward, using an inverted on-end mattress suture of the same material. This is discontinued at the vermilion border of the lip and these sutures are tied loosely so no ischemia is produced along the wound edges. With each suture, the position of the nostril is ascertained

to determine whether the resulting tension is causing any displacement. The skin sutures of C silk are placed within the floor of the nostril and continued downward until the vermilion border of the lip is reached. These are tied snugly and they are placed sufficiently close together to give the correct approximation of the skin edges. Next, the amount of the vermilion edge is determined by notching the lateral portion of the lip and making a tongue of mucous membrane and muscles from the medial side. This is sutured in place with silk or chromic catgut. In this area frequently the deficiency of lip available will cause a thinning of the edge with resulting puckering deformity in later life. If the necessary thickness cannot be obtained, an extension of the previously marked skin lines is carried out along the vermilion cutaneous border until the required amount of tissue is secured. The upper border of the mucous membrane under the lip is sutured loosely to the mucous membrane of the alveolar ridge. When this is not closed, it will frequently lead to a flattening of the upper lip because of adhesions. A prolapse of the ala cartilage into the nostril can be sutured in its normal position with sutures passing through the skin at the ala down to and including the lateral portion of the lower cartilage so as to assure correct healing. No tension sutures are necessary, if correct approximation and relaxation have been obtained. The wound is painted with compound tincture of benzoin and tension of the upper lip is reduced by the application of a Logan lip clamp.

There are several postoperative deformities that may be prevented at the time of operation. The most common of these is a flat, tight lip on the affected side, usually a result of sacrificing too much tissue along the edge of the cleft or allowing the mucous membrane of the lip to heal above its normal position with the mucous membrane of the alveolar ridge. This can be prevented by meticulous care in the utilization of the tissue on the sides of the cleft and also by the correct suturing of the undersurface of the lip to the mucous membrane of the alveolar ridge. If necessary, perpendicular incisions in the mucous membrane of the lip of the upper edge can be made for relaxation. A notching deformity of the lip is generally caused by the utilization of the vermilion edge of the cleft which is not as thick as that of the normal side. Satisfactory results cannot be obtained by using an underdeveloped cleft border in the repair of a lip. If necessary, as has been stated before, extension of the incisions along the vermilion cutaneous junction can be carried out until a normal thickness is obtained. Occasionally, there is an error in leaving too much mucous membrane at the edge of the lip with the result of hypertrophy of tissue in this area. Correct estimation of the amount of tissue needed will alleviate this.

Deformities of the nostril are more difficult to prevent. These include prolapse of the lower lateral cartilage into the nostril, widening of the nostril floor, insufficient formation of the nostril floor, and deviation of the columella to the normal side. By freeing the entire lower lateral cartilage and suturing it into its correct position, particularly at its angle, the buckling deformity can be avoided. Excessive width of the floor is caused usually by incorrect suturing or lack of tissue used in its formation. When there is a question of excessive narrowing of the base of the nostril, a pedicle flap already outlined must be used. The deformity caused by the deviation of the columella to the normal side is easily corrected by shifting it to a median location by procedures described above.

The formation of a "Cupid's bow" can be made by increasing the triangular area of skin left at the vermilion edge on the lateral side. If the vermilion edge on this side is extremely thin, such results are not always possible, because it must be sacrificed in order to obtain more thickness. When the plan of operation is decided upon, the operator takes into consideration the amount of scar tissue contraction that may occur, making allowance in the length of the lip, particularly in young infants. The question arises as to the advisability of removing teeth protruding into the cleft in older children. In my opinion these teeth should be removed, because they are of no value and will, in some instances, cause irritation to the under-surface of the wound.

Following operative repair, infants are given intraperitoneally 10 c.c. of normal saline per pound of body weight. The older children are given 500 to 1000 c.c. of saline by hypodermoclysis. A good measure of satisfactory results depends upon the postoperative care of these individuals. They are placed in a warm room with constant nursing attention for at least eight hours in order to prevent

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aspiration of mucus into the bronchi, to watch for symptoms of shock, and to remove the excessive amount of mucus that may accumulate over the wound surface. The hands are restrained. Feeding is begun six hours after operation. The infants are given three ounces of one per cent Karo water for approximately three feedings, at which time they are returned to their regular schedule. The older patients are allowed a full liquid diet six to eight hours following repair. The administration of postoperative sedatives is important, as an undue amount of crying causes trauma and increases swelling in the wound area. The infants receive ten to fifteen drops of paregoric every four hours, and the older children are given codeine in correct doses. Usually the temperature will rise for the first twenty-four to forty-eight hours to around 100 or 101 degrees. If this persists, an enema of one per cent Karo and one per cent salt (three to four ounces) is ordered for infants every six hours and in older children aspirin in the appropriate dose is administered. The application of an ice cap is beneficial in reducing excessively high temperature, but it should not be used continuously over a long period of time. If there is evidence of infection within the nose, throat or lungs, penicillin is started at once.

Care of the suture line of the lip is of the utmost importance. Though it is not advisable to be too zealous in cleansing this area, excessive formation of clots or scabs of secretion are removed and the lip repainted with benzoin as a protective measure daily. All sutures are removed from the lip at the end of seventy-two hours in order to prevent suture scars. If there is little swelling and reaction along the lip edge, most of the sutures may be taken out in thirty-six to forty-eight hours. It is unwise to apply ointments or powders to the suture line, as they afford little protection and obscure the process of wound healing. If infection does occur, hot wet sponges of saline are applied. The latter complication, fortunately, is extremely rare. The infants are fed with an eye dropper or an asepto syringe to prevent excessive motion of the lip, while older children use a cup or glass. Nursing from a bottle is never permitted. The Logan lip clamp may be removed at the end of seven days, but if swelling has been excessive, it should remain in place for a longer period of time. The patient usually is able to leave the hospital in seven days. Instructions are given the parents to keep the child's hands and other objects out of its mouth for a period of another two weeks. At the end of four weeks, light massage of the scar with cocoa butter or olive oil will aid in preventing excessive contraction.

In conclusion, a general resume of the development of operative repair of the cleft lip has been presented with a detailed discussion of the present day management. The preventive management of postoperative deformities has been outlined.

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Floral Eponym (56)

RUDBECKIA

RUDBECK, OLAF, 1630-1702, AND RUDBECK, OLAF, JR., 1660-1740

The two Rudbecks, father and son, were professors in Sweden. The father, when a student at the University of Padua, discovered on January 27, 1651, the lymphatic vessels of the intestine, distinguishing them from the lacteals.

Rudbeckia is a genus of asteraceous herbs, the coneflowers. The 30 species are exclusively North American. R. laciniata, the thimble weed, is a diuretic and tonic. R. hirta is used for a homeopathic preparation.

SIMPLE ADENOMA OF THE BREAST

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Simple adenoma of the breast or adenoma simplex occurs very infrequently, though it has been described by several authors. Ewing[1] made mention of it in his text, "Neoplastic Diseases". Ziegler[3] describes tubular and acinus varieties. As described in the literature, most of these tumors show a considerable growth of connective tissue. It is stated by some writers that the proliferation of connective tissue approximates that seen in fibroadenoma with which they are connected by transitional forms. The gross appearance and course are very similar to those of fibroadenoma.

de Cholnoky,[2] in 1939, from the Tumor Clinic of the New York Post-Graduate Medical School and Hospital found 40 pure adenomas in 863 female breasts, or an incidence of 5.5% in their series. Against this he found 174 cases of fibroadenoma, or an incidence of 29.5%. The other tumors in the series were cystic, connective tissue tumors, accessory breast, etc. In his series of 1291 cases there were 781 (51%) which were benign and 510 (39%) malignant. Simple adenoma is claimed by de Cholnoky[2] as occupying 1.6% of all cases of mammary disease. He accepts it as a distinct entity in contradiction to Geschicter.[4] The tumor is described by the author as being well defined, freely movable, moderately firm and rather elastic. He states that microscopic examination alone will make the diagnosis certain. Some of the benign lesions de Cholnoky[2] considers in the differential diagnosis are acute inflammatory processes, chronic inflammatory processes, chronic cystic mastitis, neoplastic disease of the breast such as lipoma, hemangioma, lymphangioma, myoma, neurofibroma, cystadenoma, fibroma, papilloma, fibroadenoma and malignant growths.

Foot,[5] in his Classification of Mammary Tumors, states that simple or granular adenoma often resembles accessory mammary tissue because of its being so well differentiated. His further statement that tumors of this type vary from small globular ones characterized by branching ducts that taper to bulbous acini to larger growths that take on a more complex appearance, the canaliculi becoming thick walled with more primitive cells and a lesion definitely canalicular in origin. The latter lesion shows many cystic dilatations and in some instances produces very bizarre structures. Both types are well encapsulated and non-malignant. He differentiates this type of tumor from the fetal adenoma described by Ewing,[1] the latter being composed of innumerable canaliculi showing a non-acinous structure and having a loose reticular stroma. In the latter the lining of the tubules show a low cuboidal epithelium resembling that of the fetal mammary gland. These fetal adenomata show active proliferation of both the epithelial and the connective tissue elements, with many mitotic figures present. They are not clinically cancerous.

Lewis,[6] in his Practice of Surgery, states that occasionally the pericanalicular type of fibroadenoma lesion contains such a preponderance of glandular structure as to warrant the term adenoma. These, he states, are relatively small and are more uniform in size than the intracanalicular tumors.

Moore[7] in his text-book accepts adenoma (simplex) as a definite entity. His description states that they arise from the large ducts and consist of either solid masses or large indefinite cells or a network of duct-like or acinar spaces. He further states that cysts may develop from the inspissated secretion that may accumulate within the spaces.

Eva Haumeder[8] reported a case of degenerating adenoma of right breast in a patient having a fibroma of the ovary. The growth was represented by a soft hemorrhagic, nodular tumor measuring 4.5 by 3.5 by 3 cm. in size. It was cystic, rather gelatinous, and encapsulated. The microscopic picture presented within a mucinous degenerated stroma a few glands, many of which were dilated to form cysts; the lining was composed of epithelial cells.

Haggard and Douglass,[9] in 1923, reported a series of 255 breast tumors. In this group they found 9 simple adenomata and 28 fibroadenomata and 10 fibromata.

Only the following ten cases of simple adenoma of the breast were encountered in 103,685 admissions in an obstetrical and gynecological hospital during

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the period from January, 1927, to October, 1945.

The case most recently encountered was that of A. T., No. 70128, age 34, married, colored. Admitted 10-9-45 with a history of having had nine pregnancies, eight of which were full term, the second being an abortion of three months. Aside from childhood diseases there had been a goiter operation in 1932. Menstrual history was normal. Two months prior to admission she noticed a tumor mass in the medial portion of the left breast at 10 o'clock on the clock dial. It had not been painful but had enlarged progressively. At the time of examination her last menstrual period and period of amenorrhea corresponded with an enlarged uterus diagnosed as six month pregnant. Examination disclosed a well circumscribed, rounded, non-tender, firm tumor mass in the upper medial portion of the left breast measuring 7 cm. in diameter. It was not attached

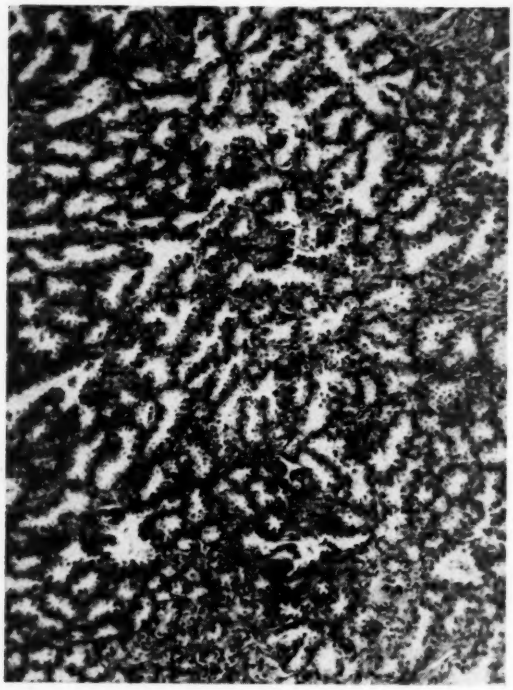

Figure 1. Section showing uniform acinar arrangement (simple adenoma) from first case, Mrs. A. T.

to the overlying skin and was movable. Laboratory tests including serology were negative. On examination the tumor was circumscribed and encapsulated; it was irregularly lobulated. It had the feel of soft rubber and on section the surface was moist and tan. On microscopic section it was composed of acinar tissue with a few distended thin-walled ducts at irregular intervals through the acini. At times lymphocytes were scattered through the stroma. Pathologic diagnosis: Simple adenoma of breast.

Figure 2. Section showing intra-canalicular fibro-adenoma—to contrast with Figure 1.

Resumes of other cases encountered:—

C. S., No. 635, age 19, white, single. Admitted 2-3-27 with a history of a small mass in the right breast noticed for a period of 3-4 months. Serology and laboratory work were negative. The mass was removed and found to consist of a small spherical tumor 2 cm. in diameter surrounded by a white fibrous capsule. The tumor itself was soft and meaty. Section was made up of gland-like tissue. At one side the structure was that of mammary gland, but in the center the cells were more heaped up and the epithelium lining the gland spaces was much thicker. The fibrous tissue stroma was sparse. Pathologic diagnosis: Adenoma of breast.

T. S., No. 830, age not stated, married, white. Patient admitted 5-15-29 because of a tumor mass in the left breast and a diagnosis of chronic appendicitis. Serology and other laboratory work nega-

tive. The mass in the left breast measured 4 cm. in diameter and seemed definitely encapsulated by connective tissue and some breast tissue. It was firm, irregularly lobulated and slightly yellow in color. Numerous irregular cysts were present throughout. Microscopic section showed an extreme increase in the number of acini, otherwise relatively normal in themselves. The mild hyperplasia of the acini resembled much that seen in the acini of a lactating breast. The stroma was of young connective tissue type, seemingly rapidly growing and infiltrated with lymphocytes. A number of large spaces traversed the tumor irregularly. These were lined by low epithelium which often proliferated into papillary projections. Pathologic diagnosis: Simple adenoma of breast.

E. M., No. 1014, age 30, married, white. Admitted 11-5-33 with complaint of vaginal discharge and mass in the right breast. Mass in the right breast had been noticed for a period of 3-4 years and had shown some progressive enlargement with tenderness during her menstrual periods. Serology and laboratory data were negative. The mass in the right breast consisted of a firm, encapsulated, lobulated, irregular shaped tumor, the cut surface of which had a peculiar "meaty" appearance. Microscopic section showed a dense fibrous and collagenous connective tissue stroma in which were numerous scattered glandular structures. The acini and ducts were lined with low columnar epithelium, which was often moderately hyperplastic. The acini were in places round or ovoid while in other places they were elongated and tortuous, tending to be compressed by the dense stroma. Diagnosis: Adenoma simplex of breast with tendency to be intracanalicular fibroadenoma.

M. R., No. 2255, age 30, married, white. Admitted 10-21-34 with chief complaint of mass in the right lower breast which was noticed one month prior to admission and which showed no change in its size or general characteristics. Serology and laboratory work negative. Specimen consisted of a small mass of soft white tissue, the cut surface of which was white, glistening and rubbery. Microscopic section showed the glands to be increased in number, the acini and ducts generally compressed and elongated with an increase in the connective tissue of the stroma. The general architecture varied from beginning simple adenoma to pericanalicular and intracanalicular adenoma. Pathologic diagnosis: adenoma of breast (mixed type).

G. R., No. 23453, married, white. Admitted 1-25-37 with chief complaint of mass in right breast. Swelling in right breast had been noticed five weeks prior to admission and had shown slight progressive enlargement. The breast was definitely sensitive and tender. Serology and laboratory work negative. This mass on removal measured 5 cm. in diameter and was disc shaped, the cut surface of which showed a grayish yellow appearance studded with yellowish-brown spots. The epithelium was normal. The glands were surrounded by a small amount of loose stroma in which there was an occasional lymphocyte. The greater part of the section was made up of firm connective tissue rich in collagen. The glands on microscopic section were of average size and not increased in number although along one border the glands were distinctly increased in number and showed a mild change in the appearance of the epithelium with the cells smaller in size and more deeply stained. Pathologic diagnosis: Mild chronic mastitis with areas of simple adenoma.

M. M., No. 40529, age 50, married, white. Admitted 6-18-39 complaining of a mass in the outer half of the right breast which was non-tender and about 1 cm. in diameter. Serology and other laboratory information were negative. The mass following removal was small, white and encapsulated. It was composed of dense fibrous tissue in which lay enmeshed a large number of islands of breast tissue and a few dilated ducts. The acini at times became confluent and were larger than involuting structures. Pathologic diagnosis: Simple adenoma of breast.

M. H., No. 40831, age 42, married, white. Admitted 9-7-39 with a chronic mastitis of the left breast, post-abscess inflammatory reaction of the left breast, multiple abscesses of left breast which were treated with simple mastectomy 9-9-39. Serology and laboratory work were negative. Sections of the breast showed intense chronic mastitis with multiple abscesses from which staphylococcus aureus was cultured from the pus. Some of the sections from the region of the nipple showed a localized tumorous formation consisting of an adenomatous overgrowth of breast glands. The glands had taken on a different character and formed a loose network of acini lined by a low vacuolated epithelium. Diag-

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nosis: Intense chronic mastitis with multiple abscesses, simple adenoma of breast.

S. T., No. 41926, age 15, single, colored. Admitted 3-14-40 with a chief complaint of lump in right breast which had been present for a year or more and which had increased progressively in size. Serology and laboratory work negative. On removal the tumor measured 5.5 by 5 by 4 cm. It was of uniform rather soft consistency and had a tan yellow appearance throughout. Microscopic section revealed a marked increase in the acinar structures in a fibrous stroma of varying density. The gland structures varied somewhat in size but generally were uniform and orderly. Diagnosis: Simple adenoma of breast.

B. P., No. 48623, age 21, married, colored. Admitted 4-11-41 with chief complaint of tumor in left breast. History of having had trouble with this breast post-partum two years prior to admission followed by the development of a lump in the outer lower quadrant of this breast. Serology and laboratory work were negative. On removal the specimen was a lobulated tumor mass 6 cm. in diameter, the cut surface of which was pinkish white. The microscopic section showed breast tissue which was composed of many actively growing ducts separated by strands of loose fibrous tissue in which there were loose scattered lymphocytes. Pathologic diagnosis: Adenoma of breast.

TREATMENT

Surgical removal is the only form of treatment. All solid tumors of the mammary gland should be removed regardless of the patient's age or sex. Such removal is imperative not only to relieve the patient's mind, but because only surgical removal supported by pathological examination can rule out malignancy, even though in the second and third decades of life malignant lesions of the breast are rare.

It is recommended that the growth be excised together with the corresponding sector of the breast in order to properly eradicate the lesion and prevent recurrence. The type of incision is not important and may be either the simple radial incision or the more esthetic circular incision in the fold of the breast or encircling the areola. X-radiation has been considered as an available form of therapy by some but this is not generally accepted.

SUMMARY

1. Ten cases of simple adenoma of the breast were found in 103,685 admissions in an obstetrical and gynecological hospital over a period of 20 years, giving an incidence of 1 in 10,000.

2. Simple adenoma of the breast is a benign tumor which may develop at any time during the reproductive period of life.

3. Simple adenoma of the breast is usually well encapsulated, freely movable, firm, solid and rarely attached to the skin and surrounding tissues.

4. Differentially, the greatest risk or error may be in the possible presence of malignant disease which may simulate fibro-adenoma. Accurate diagnosis is made only by microscopic examination.

5. The treatment is surgical excision.

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GRANULOSA CELL TUMOR OF THE OVARY

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In recent years there has appeared in medical literature an increasing number of case reports on granulosa cell tumor of the ovary. The most recent of these is a report from the Mayo Clinic covering 62 cases. At the American University Hospital this tumor has been seen but twice in the last twenty-five years despite the fact that the tumor has been sought diligently in the pathological material which has passed through our laboratories.

Granulosa cell tumors are the effeminizing tumors of the ovary. They secrete excessive amounts of estrogen and possibly some progestin. The changes they produce are the result of estrogenic stimulation. They cause the most striking changes before puberty and after menopause. During the period of sexual activity little change may be induced because the ovaries are already in full activity. Before puberty these tumors give rise to precocious sexual maturity; after the menopause sexual rejuvenation is the clinical picture.

Incidence.—Novak and Brawner found 20 such tumors from among the 40,000 gynecological specimens of the Johns Hopkins Hospital. It comprises about 10 per cent of all solid malignant ovarian tumors. The tumor may develop at any age. Less than 10 per cent occur before puberty; 30 per cent after menopause; the majority of cases, between the ages of 30 and 50 years. It is more frequent in childhood than in old age. During the past 8 years 2 cases have been seen in the American University Hospital.

CASE REPORTS

Case 1: Mrs. M. M. M. admitted to Gynecological Service on November 7, 1945. Past medical history negative except for amœbic colitis 2 years ago—treated. Age, 45; married 20 years; 3 living children, youngest 14 years. Four abortions (4, 3, 2, 2 months—all induced) last 5 years ago.

Chief Complaint: Severe attacks of pain in the right lower quadrant of the abdomen and back without fever of 2 years' duration diagnosed as amœbic colitis and chronic appendicitis and treated by hot applications externally with temporary relief. One doctor diagnosed "enlarged right ovary" and gave foreign protein injections with relief for approximately 2 months. Symptoms are occasionally associated with heavy meals. Menstruation before present illness was regular; once every 30 days, 4 days' duration, moderate amount; last menstruation September 15, 1945. Menses became irregular in present illness, coming once every 15 to 20 days with periods of amenorrhea lasting about 2 months. Menses have been scanty during the last 8 months.

Physical Examination: There are no positive findings except for slight tenderness on deep pressure over the right lower quadrant. An enlarged, hard, discrete lymph gland in the right inguinal region, 2 cm. in diameter, is palpated.

Pelvic Examination: External genitalia are normal. A cystic tender mass in the right and left fornix about 4 cm. in diameter can be palpated. Both tubes are palpable and tender. Anterior and posterior fornices are normal. Cervix is lacerated, soft, directed anteriorly. Uterus is in normal position, slightly enlarged; motility is limited.

Laboratory Study:

R. B. C.	4,390,000 per cu. mm.
W. B. C.	8,600 per cu. mm.
Blood Urea Nitrogen	12 mg. %
Blood Sugar	80 mg.
Blood Wassermann	Negative
Urine Examination	Negative
Urine Culture	E. coli communis
Stool Examination	Negative
Stool Culture	Negative

X-ray of Chest: Essentially negative.

X-Ray of Gastro-Intestinal Tract: Mild gastritis and spastic colitis; no demonstrable ulcers.

Operation: Patient was operated upon Novem-

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ber 17, 1945. About 25 c.c. of cloudy, hemorrhagic, free fluid was found in peritoneal cavity. Peritoneum was smooth. Extensive pelvic and intestinal adhesions were found between the uterus, ovaries, and tubes. Uterus was invaded by small nodules of tumefaction on its surface. Uterus was larger than normal. Both tubes were tortuous. The ovaries were replaced by papillary cystic tumefaction about 4 cm. in diameter. The posterior lumbar-sacral lymph nodes were enlarged. *Bilateral salpingo-oophorectomy and supravaginal hysterectomy* was done.

Post-Operative Course: Uneventful.

Pathology: Specimen consists of the fundus uteri, tubes, and ovaries. The fundus uteri is 6x5x4 cm. The mass that represents the left ovary is 5x4.5x3 cm. and the mass that represents the right ovary is 7x3.5x3.5 cm. and contains a gelatinous cyst 2.5 cm. in diameter. Both masses have a nodular surface with adhesions to the tubes. Secondary small tumors are seen on the peritoneal surface of the fundus. (Fig. 1).

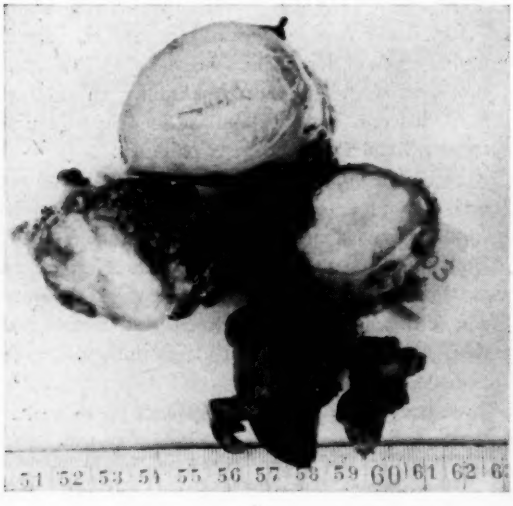

Fig. 1.

(a) *The Fundus Uteri:* The fundus uteri is 6x5x4 cm. The thickness of the uterine muscle is 13 mm. The thickness of the endometrium is 5½ mm. On the anterior surface of the uterus there are several small nodules. In different fields there is invasion of the uterine muscularis by islands of endometrium—adenomyosis, and the endometrium shows a marked degree of hyperplasia—Swiss cheese type.

(b) *The Fallopian Tubes:* The fimbriated ends of both tubes are incorporated in the corresponding masses. However, on the left side, the tube is transformed to a cystic mass 2 cm. in diameter. This mass, on section, contains gelatinous material and fungating tumor projections.

(c) *The Masses Representing the Ovaries:* The right mass is 7x3.5x3.5 cm. and the left mass is 5x4.5x3 cm. Both are rounded, smooth in some parts, nodular in others. Both are solid and firm and on section have 2 distinct components, a peripheral layer of ordinary ovarian stroma surrounding a whitish tumor which is firm in texture and has a tendency to lobulation.

Fig. 2.

Microscopic Examination: The ovarian stroma is invaded by a neoplasm. The tumor is actually multiform, i.e., in certain areas it is in sheets, in others,

spindle cells, and in others, pseudoalveolar arrangements are seen. Some of the large pseudoalveolar spaces contain colloid. The small ones are very numerous and some of them convey the impression of aborted ova. The tumor cells are very pleomorphic, with very indistinct cell boundaries. Their nuclei are round or oval, hyperchromatic, vesicular, and do not possess prominent nucleoli. Mitotic figures are numerous and tumor giant cells are seen in different fields. The tumor has invaded the mucosa of the fallopian tubes. (Fig. 2).

Pre-Operative Diagnosis:

1. Chronic pelvic inflammatory disease with adhesions
2. Chronic salpingitis, bilateral
3. Cyst of the ovaries, bilateral.

Post-Operative Diagnosis:

Papillary cyst adeno-carcinoma of the ovaries with metastasis.

Histological Diagnosis:

1. Bilateral granulosa cell tumor of the ovary—malignant with metastasis
2. Hyperplasia of the endometrium.

A follow-up examination on this patient one month after operation revealed extensive metastasis to the lungs.

Fig. 3.

Case 2: Mrs. T. A. K., age 36 years, married 17 years, gravida III, para II (one stillbirth 4½ years ago) was admitted to Gynecological Service on January 22, 1937.

Chief Complaint: Menorrhagia of 20 years duration, 8 days flow, profuse amount, irregular cycle. This condition changed to meno-metrorrhagia 4½ months ago. There has been no pain and no fever.

Physical Examination: There is a firm, movable tumor size of a 7 months pregnancy arising from the pelvis.

Pelvic Examination: External genitalia are normal and fornices are clear. Cervix is normal. The uterus is enlarged, anterior, and to the right of the mass. The mass seems to be arising from the left lateral part of the uterus, but does not form a part of it. There is no tenderness. Patient was subjected

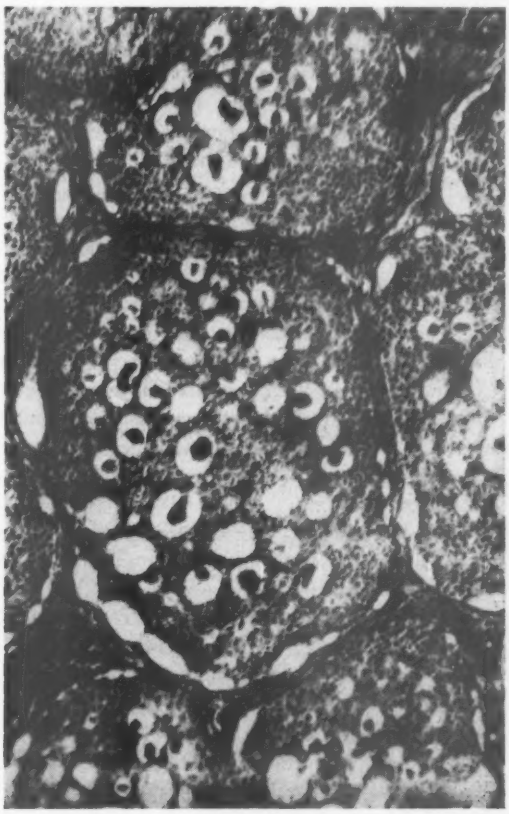

Fig. 4.

to operation on January 23, 1945. Uterus was the size of a 3 months pregnancy, symmetrical, hard and fibrotic. Both tubes and right ovary normal. Left ovary was replaced by a tumor about 15 cm. in diameter.

Operation: Left salpingo-oophorectomy, supravaginal hysterectomy.

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Post-Operative Course: Uneventful.

Pathology: Specimen consists of left ovary, tube and uterus. A round symmetrical tumor 15x15 cm. adherent to the tubes has replaced the left ovary. It is rounded, solid, smooth, and firm. On section it is covered with a peripheral layer of ovarian stroma; the mass is yellowish, cuts easily, firm in texture, apparently globulated. (Fig. 3).

Histology: The ovarian tumor is enclosed within a thin layer of ovarian stroma. The neoplasm has developed in the form of nests surrounded by loose ovarian stroma. In some of the large nests the cells are in solid sheets, while in others the sheets surround large spaces which contain a thin colloid material. In the smaller nests the tumor cells have taken a pseudoalveolar arrangement, and in many of the spaces thus formed thick colloid is found. Scattered throughout the tumor are nests which resemble atypical graafian follicles.

The tumor cells are very pleomorphic. In the large nests they are polyhedral with delicate cell membranes, pale granular cytoplasm, and round or oval vesicular nuclei, each containing a single prominent eosinophilic nucleolus. In the smaller nests the cells are compressed and have taken a columnar or spindle appearance. In some foci the cells are arranged radially. The nuclei are hyperchromatic and each contains a single prominent eosinophilic nucleolus. The endometrium is hyperplastic of the Swiss cheese type. (Photo-micrograph of histology, Case 2. Fig. 4).

Pre-Operative Diagnosis: Uterine fibroid, pedunculated.

Post-Operative Diagnosis: Left ovarian cyst, fibrosis uteri.

Histological Diagnosis: Granulosa cell tumor of ovary; chronic metritis with fibrosis.

Patient came for check-up only once 6 months later and could not be followed after that visit. Pelvis was clear at the time of this last examination and there was no evidence of recurrence or spread.

DISCUSSION

Two granulosa cell tumors are presented which were not diagnosed except by the histological examination. This was probably due to the fact that the hyperestrogenism occurred while our patients were still having full active ovarian function. Granulosa cell tumors occurring in the adult period do not give striking symptoms.

The two cases illustrate the extremes which these tumors may present in the matter of malignancy. One was highly anaplastic and clinically malignant, the other histologically benign and the clinical course confirmed the histological impression.

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Medical Arts Building,
Richmond, Virginia.

Schering Field Staff Increased.

The addition of 14 new representatives to Schering Professional Service staff has recently been announced by the Schering Corporation of Bloomfield and Union, New Jersey, manufacturers of endocrine and pharmaceutical preparations for the medical profession.

Twelve of the new representatives have been assigned to the Domestic Sales Division, for service in various territories throughout the country. Prior to assuming their duties they completed an intensive five weeks' training course in scientific and technical fields and in professional service. Two new representatives of the Schering Foreign Sales Division also completed the training course. These especially trained men are a part of the present Schering policy of expansion.

SCHICK, DICK AND TUBERCULIN TESTING IN A RURAL VIRGINIA SCHOOL

HUGH H. HANSON, B.S., M.D.,
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Located on the southern shore of the Potomac river at Dahlgren, Virginia, is a rural grammar school which serves as the fountain of education for those children whose parents reside on the U. S. Naval Proving Ground. The school staff is composed of a principal and eight teachers; it is attended by approximately one hundred and sixty children; and the children are taught from the kindergarten through the eighth grade. Through the cooperation of the principal and students, a health program was recently instituted there; and a part of the findings comprise the body of this report. Since this school is comparable to many rural schools in the State of Virginia, these findings may be of interest to others.

This article is prefaced by stating that it is a report of the findings in this particular school. This study does not represent a cross section of Virginia's rural schools; the numbers considered are far too small to be of statistical value within themselves; and the isolation, abundance of fresh air and sunlight, and relative freedom from extreme poverty make this school somewhat unique.

In initiating this program, a routine history and physical examination was completed on every student and teacher. The status of general health was good, and malnutrition was a rarity. The results of this routine work will not be elaborated upon at this time, and the portion of the program concerned with preventive medicine will be presented.

If the level of student health is to be elevated by the intelligent application of sound epidemiological principles, the level of immunity (or susceptibility) must be known; therefore the Schick, Dick and tuberculin tests become mandatory in both students and teachers. A reduction in student morbidity and conservation of school days can be effected through the observance and exercise of these principles.

SCHICK TEST

The recommended technique was rigidly followed, and 0.1 cc. of a standard Schick test toxin was injected intracutaneously. The reaction was read and recorded after seventy-two hours. This test was performed to determine susceptibility to diphtheria.

SCHICK TEST DATA

Av. Age Yr.	Grade	Schick Pos.	Pos. Prev. Imm.	Schick Neg.	Neg. Not Imp.	Total Tests	Prev. Cases Diph.	Prev. Schick Tests
33	T	3	1	6	4	9	0	3
. . . . .								
13	8	1	1	21	5	22	1	17
12	7	1	0	18	2	19	1	12
11	6	0	0	11	4	11	1	3
10	5	1	1	19	3	20	0	10
9	4	0	0	20	3	20	0	5
8	3	1	0	12	2	13	0	3
7	2	2	1	13	1	15	0	5
6	1	8	3	13	1	21	0	6
5	K	3	0	17	0	20	0	1
Totals		17	6	144	21	161	3	62

In this school, 89% of the children tested were Schick-negative (possessed more than one-thirtieth unit of circulating antitoxin per cc. of blood serum); and are relatively protected from clinical diphtheria with its complications and sequelae. The past incidence of diphtheria among this group is 1.8%, which means the disease has been virtually eliminated from this community by immunization, but not the presence of virulent *C. diphtheriae.* Inoculation with some form of antigenic material had occurred in 80% of these children, resulting in a Schick-conversion rate of 94.5%. This rate is in accord with that reported by Fulton and his colleagues (1942) in their survey using APT. Alum-precipitated toxoid alone was used as the antigenic material in 80% of these children, and in the remaining 20% it was combined with various other antigens. There were no failures of Schick-conversion noted in those children inoculated with the combination of antigens; however, these are of more recent vintage, and have not enjoyed the wide use of the APT alone. Since 5.5% of those inoculated failed to develop enough circulating antitoxin to effect protective immunity, it becomes important that inoculation be followed in three to six months with a Schick test; and those who are Schick-positive further inoculated. If we wish to approach 100% protection by artificial inoculation, use of the Schick test is inevitable. Although the failures of Schick-

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conversion are few, they are sufficient to provide the community with clinical diphtheria, even though every inhabitant was inoculated. We must realize that virulent diphtheria bacilli are always present in a community; and those persons not inoculated, and those receiving insufficient toxoid will perpetuate the disease.

Even the scant data presented here enables one to realize that active immunity is acquired rather rapidly after the school age is reached by contact and subclinical infection; and by adulthood 70% to 80% of the population will be Schick-negative. Therefore our efforts must be directed to that period of life elapsing between the disappearance of inherited immunity and the subsequent development of immunity from subclinical infection (one to six or eight years of age).

In this group of children 38.5% had been Schick-tested previously, indicating that some of the parents are aware of the value of this test, and do not rest in the false security conferred by inoculation alone. Grant (1945) in his recent survey emphasizes the fact that latent immunization of a community goes on rapidly by contact with carriers of virulent bacilli, and also the favorable modification of the clinical disease in Schick-negative individuals as contrasted with its malignant and fulminating character in those who possess inadequate immunity for Schick-conversion.

DICK TEST

Using a standard scarlet fever toxin, 0.1 cc. was injected intradermally, and the results read and recorded after twenty-four hours. This test was performed to determine susceptibility to scarlet fever.

DICK TEST DATA

Av. Age Yrs.	Gr-ade	Pos. Dick Pos.	Pos. Freq. S.T.*	Pos. T.P.*	Neg. Dick Neg.	Neg. Freq. S.T.*	Neg. T.P.*	Total Tests	Prev. Dick Test	Prev. Cases Scar. F.
33	T	1	1	1	8	0	7	9	2	1
. . . . .										
13	8	7	2	4	15	7	10	22	0	1
12	7	12	2	5	7	3	3	19	0	2
11	6	7	4	3	4	0	3	11	0	0
10	5	12	5	6	8	2	6	20	1	2
9	4	15	5	10	5	2	3	20	1	1
8	3	11	6	6	2	1	2	13	0	2
7	2	9	5	6	6	2	3	15	0	4
6	1	20	11	15	1	0	0	21	1	0
5	K	19	6	16	1	0	1	20	0	1
Totals		112	46	71	49	17	31	161	3	13

*S.T.—Sore Throats and T.P.—Tonsils present.

The preceding data show 70% of these children to be Dick-positive reactors and susceptible to the scarlatinogenic streptococci. The per cent of positive reactors here is practically the same as that obtained by Dyer and his colleagues (1926) in their rural survey. Of the 30% of Dick-negative individuals, 8% had been victims of scarlet fever; we may safely presume that 22% acquired active immunity by subclinical infection of the scarlatinogenic streptococci. Very few of these children show active immunity acquired through subclinical infection before approaching adolescence; but one can accurately assume that only 20% to 30% will be Dick-positive reactors after adulthood. In view of the data presented, there is no statistical basis for any conclusion regarding the absence or presence of tonsils and the frequency of sore throats in the process of developing immunity through subclinical infection. The only conclusion tenable is that there are more tonsils present in the younger age groups, and these possess less immunity to scarlet fever.

The Dick-positive reactors here are approximately triple the per cent reported by Grand and Purvis (1945) in their survey; but this is explained by the younger age group tested and their natural isolation from urban congestion with its bacterial exchange. Pike and Fashena (1946) report a greater incidence of group A hemolytic streptococci present in the tonsils of children from five to nine years of age, and subsequently a marked decrease in incidence and replacement by group C. Their findings justify the frequency and severity of scarlet fever in pre-school age children, for they have had very little contact with this organism and hence have developed no immunity. Also, it appears to explain the rapid disappearance of susceptibility upon approaching adolescence and adulthood, for previous contact with the offending organism has resulted in sufficient active immunity to render them non-susceptible.

The Dick test for susceptibility has been sadly neglected in public schools and the practice of medicine. Practically all sporadic cases of scarlet fever should be subsequently checked with the Dick test to confirm the clinical diagnosis, especially if the case is doubtful or atypical. This test is of paramount importance in the conservation of school days when scarlet fever is endemic or potentially epidemic; for those children who are Dick-negative

should not be forced to remain at home following exposure and sacrifice valuable school days. The results presented show that 42% of the children in the upper five grades of this school could safely attend school every day without endangering themselves or others, even in the face of an epidemic. Through the employment of this simple test, much useful information may be gleaned.

TUBERCULIN TEST

The intradermal (Mantoux) test was employed, and 0.005 mg. purified protein derivative injected. The tests were read and recorded after forty-eight hours. Standard recommended technique was observed. This is a test for the sensitivity to the protein of the tubercule bacillus which results from infection.

TUBERCULIN TEST DATA

Children		
Total Tests	161	
Tuberculin Positives	23	(14%)
Active Cases Discovered	1	(0.6%)
Active Tuberculosis in Family	2	(1.2%)
Rotengenograms of Chest	23	
Calcified Gohn Lesions	6	(26%)
Teachers		
Total Tests	9	
Tuberculin Positives	5	(55%)
Roentgenograms of Chest	5	

Of the nine teachers tested, 5, or 55%, were tuberculin-positive; and of the one hundred and sixty-one children, 23 or 14% were positive. This means that 14% of these children have been subjects of a primary tuberculous infection, and may possibly harbor virulent acid-fast bacilli in their fibrotic or calcified lesions. The chests of all tuberculin-positives were subsequently x-rayed, and one case of active minimal pulmonary tuberculosis discovered. Calcified Gohn lesions were observed in 6, or 26%, of these roentgenograms. Inquiry revealed children from only two families with active pulmonary tuberculosis in the immediate family.

The active case of tuberculosis discovered was present in a male child eight years of age, and he gave a three plus tuberculin-test characterized by a local, focal, and generalized reaction. The paternal parent is known to have active pulmonary tuberculosis, and this child should have been diagnosed previously by the family physician. It is the universally accepted responsibility of every physician who diagnoses a case of active pulmonary tuberculosis, primary or reinfection, to tuberculin test and x-ray the chest of every member of the immediate family. This responsibility can not be shirked if we are to control the spread of tuberculosis.

Since most reinfection tuberculosis becomes manifest in the late teen-ages or early adulthood, the tuberculin test among school children has suffered a marked loss of popularity. This is regrettable, for the tuberculin test is one of the few tests which is significant whether negative or positive. Periodic testing of school children who are tuberculin-negative is one of the most efficient ways of discovering the primary infection. The tuberculin test may become positive before clinical signs and symptoms are manifest, especially in those cases with a good prognosis. In these cases which make an uneventful recovery, our only problem is spread of the disease; therefore, by discovering and isolating the primary infections, spread of the disease will be decreased. Periodic testing would allow us to eradicate active tuberculosis from the schoolroom. Myers and colleagues (1945) have pointed out that the progress of tuberculosis control in a community can be determined by periodic tuberculin testing; for any increase or decrease in the basic per cent of positive tests among children reflects the progress or failure in the control of active adult tuberculosis.

The tuberculin test must be used in conjunction with the roentgenogram if active tuberculosis is to be controlled. Very little progress can be made using either alone. Gass and colleagues (1943), in their studies, found roentgenographic pulmonary calcification in large numbers of school age children who showed a relatively low percentage of positive tuberculin reactions. Sweary (1933) found that only 20% of the primary tuberculous infections in the chest showed detectable roentgenographic changes. Therefore, roentgenograms alone would miss 75% to 80% of these cases.

The tuberculin patch-test has many obvious advantages; and Reisman and Grozin (1941) state that the non-commercial tuberculin patch-test is reliable, and compares favorably with the intradermal (Mantoux) test performed with 0.1 mg. of a 1:1000 dilution of old tuberculin. The literature is filled with discussions concerning this and various other methods. For routine periodic testing, the patch-test is cheap, easily applied, may be used by a school nurse, and will certainly suffice where the Mantoux is not available.

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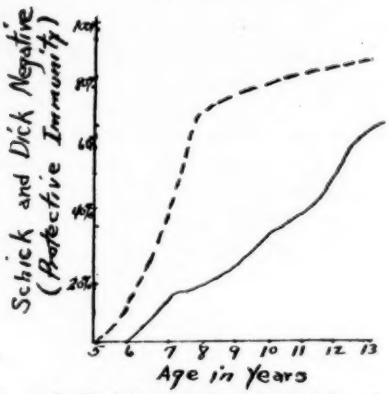
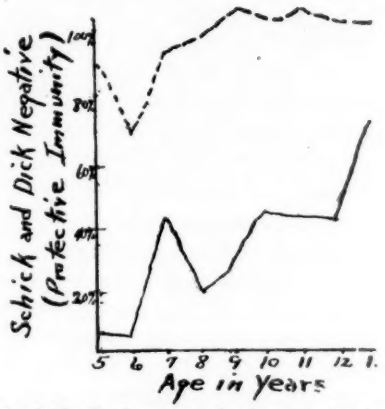
COMMENT



Graph I. Protective Immunity acquired by subclinical infection as related to age in this school.



Graph II. Total per cent showing protective immunity as related to age in this school.

------ Diphtheria
—— Scarlet Fever

The status of active acquired immunity due to subclinical infection by the scarlatinogenic streptococci of scarlet fever and the bacilli of diphtheria in this school is depicted above in Graph I. Active acquired immunity in the absence of clinical infection is very similar in both scarlet fever and diphtheria. Following birth the inherited immunity to these diseases disappears after six months to one year; then it begins to rise again at four to six years of age and reaches a maximum in adulthood with 75% to 80% of the population possessing adequate protective immunity (Schick negative and Dick negative).

Graph II represents the general level of protective immunity in this school. The immunity to diphtheria is excellent, and with a little work can be made to approach 100%. An epidemic of diphtheria could not occur in this school. Immunity to scarlet fever is very poor, and our only safeguard from an epidemic is the low invasiveness of the organism and clinical vigilance with prompt isolation of all Dick-positive reactors when the disease is present. The high immunity to diphtheria has resulted from the widespread artificial inoculation of infants, and from the efforts of the State in making people conscious of the disease. The lack of immunity to scarlet fever can be explained by the natural isolation and low age of this group, and the absence of a generally satisfactory method of artificial immunization.

The health of that 86% of these children who are tuberculin-negative depends upon subsequent periodic tuberculin testing and x-raying of positives. There is no doubt that some of these children will succumb to the acid-fast bacillus during the prime of life; and their recovery as well as the spread of the disease will depend upon early recognition, treatment and isolation. Whether this 86% is fortunate or unfortunate will depend largely upon how well the spread of tuberculosis is controlled.

CONCLUSIONS

1. The requirements for admission to a State school should include smallpox vaccination, a negative Schick reaction, a known Dick reaction and a tuberculin test followed by a roentgenogram of the chest when positive.

2. These requirements must be complied with by teachers and students alike, for, due to their close association, their health is interdependent one upon the other.

3. Diphtheria inoculation should be performed early in life to avoid the adverse reactions associated with immunizing older individuals, and followed by the Schick test until conversion is effected.

4. The Dick test should be used more frequently to confirm clinical diagnosis, and to conserve school days lost by the isolation of Dick-negative children.

5. A tuberculin test should be performed on every child early in life and followed by a roentgenogram of the chest if positive. Those who are negative should be tuberculin tested periodically,

and when the reaction becomes positive every effort should be exerted to determine the exact status of the infection in the child.

6. We should become more cognizant of school health. The epitome of health is *mens sana in corpore sano*, and this should be the aim of Virginia for all of her school children—her generation of tomorrow.

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New Books.

The following are recent additions to the Library of the Medical College of Virginia and are available to our readers under usual library rules:

Artificial human insemination.

Boyd—Blood grouping. (Annals of the N. Y. Acad. of Sciences.)

DeLee—Principles and practice of obstetrics. 9th ed.

Gifford-Adler—Textbook of ophthalmology. 4th ed.

Hagan, *et al.*—The relation of diseases in the lower animals to human welfare. (Annals of the N. Y. Acad. of Sciences.)

Kamen—Radio-active tracers in biology.

Lawton—Aging successfully.

Modern medicine annual—1947.

Rasmussen—Some trends in neuroanatomy.

Shryock—The development of modern medicine.

Spock—The common sense book of baby and child care.

Wortis *et al.*—Physiological and psychological factors in sex behavior. (Annals of the N. Y. Acad. of Sciences.)

Upjohn Opens Chicago Branch.

On January 1, 1948, The Upjohn Company, Kalamazoo, Michigan, manufacturers of pharmaceuticals since 1886, will open a new branch office and warehouse at 1001 East 87th Street, Chicago, Illinois. The building is modern and functional in appearance and construction, and is located near the residential section of Chicago's south side, just a few steps from the Illinois Central Railroad's suburban service. This branch will employ about fifty people at the start in the office and shipping departments, and will enable the Company to give the best possible service to customers in the Chicago and Illinois areas.

Final Edition of "Courage and Devotion Beyond the Call of Duty".

The final edition of the book, "Courage and Devotion Beyond the Call of Duty," which is composed of official awards and citations received by U. S. medical officers during World War II, is now being prepared by Mead Johnson & Company, Evansville, Indiana.

Any physician, who has not already done so, should write to Mead Johnson & Co. advising them of the awards he has received and also send a typewritten or photostatic copy of his citations. The following additional information would be of assistance in compiling the material for this book: Present rank or rank at time of discharge. Branch of service. From what university and in what year M. D. degree was received. Date of entry into the service.

XUM

THE TREATMENT OF ACUTE NEPHRITIS*

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We propose to discuss the treatment of the situation seen in a young adult who, a week or ten days after an upper respiratory infection or the so-called "strep throat", develops edema of the face, oliguria, and hematuria. This process which we term acute nephritis is, as everyone knows, a *generalized* disease. It is *not* a disease of the kidney alone, but rather some little understood process in which there is generalized arteriolar spasm with secondary elevation of the blood pressure in the acute stages and evidence of kidney damage in the later stage. Thus, there are two problems of management—one, the acute, and the other the subacute or convalescent phase.

Since the basic nature of the disease is little understood, there is no really specific treatment for the acute phase. The patient is put to bed and given food and fluids in moderation. The latter consist of water and fruit juices. The formerly recommended milk diet has not been so strictly followed. Protein is limited. The blood pressure is followed closely because its trend appears to be the most important item as to how the patient is progressing; if the pressure is stabilized or dropping you may feel a sense of relief; if it is rising, trouble may be anticipated. In any case, we are on the look-out for evidence of vascular disturbance in the brain, such as drowsiness, coma, vomiting, and *convulsions;* for signs of cardiac failure, such as dyspnea, hepatic engorgement, edema of lungs, and pleural effusion; and manifestations of kidney failure, such as further diminution of urinary output toward or to anuria.

It is felt that phenobarbital, or similar drug, should be employed where disturbance of the brain appears to be the chief difficulty. Should this drug not exert the desired control 3 to 5 grams of magnesium sulphate is given intravenously. If, following this, the blood pressure drops, the convulsions cease, and the patient rouses, it is felt that the desired effect has been attained and the medication may be repeated in some hours as indicated. When using magnesium sulphate intravenously, calcium gluconate is always kept at hand as the relaxation from the magnesium may be greater than anticipated. The calcium will promptly relieve the collapse occasionally induced by the magnesium. At times repeated spinal punctures have been employed to decrease the intracranial pressure.

In other cases cardiac failure has been our chief concern. This phase of acute nephritis is much more important than has been realized. In these patients rapid digitalization is desirable and digitoxin appears to be the drug of choice.

As a rule our attention is centered on the kidney, involvement of which is, as said above, only a part of the problem. If kidney failure seems to be the chief difficulty and less and less urine is being excreted, little can be done. In the presence of anuria operative procedures must be considered. Lumbo-dorsal sympathectomy has been done by Smithwick, as reported by Butler and Reyersbach.[1] Decapsulation of the kidney may be employed.

Toward the latter part of the acute stage anemia may be quite a problem. For this we have resorted to transfusions, always with some hesitation because of our anxiety over the possibility of a transfusion reaction adding to the burden of an already damaged kidney.

As you know, there is a close relationship between acute nephritis and infection, particularly streptococcus infection, so that it seems desirable to make use of pencillin. The sulfonamides were formerly advocated for the infection but it has always seemed to us that the risk of further damage to an already diseased kidney outweighed any possible benefit.

In the acute stage, then, we are interested particularly in the *brain* and *heart* as well as the kidneys and on the look-out to control evidence of activity in these areas.

The later stage is exemplified by the patient who appears to be entirely well and yet continues to show albumin, casts, and red cells in the urine, or these are increased over normal as in the Addis count, or the sedimentation rate remains elevated, or some combination of these changes exists. Should we consider such patients as having active disease and prescribe bed rest with the idea that we cannot

*Read at the Symposium on Therapy, February 18-19, 1947, Medical College of Virginia, Richmond, Virginia.

rest the kidney without resting the patient? Such a program may continue for months and months. In a few patients we have not seen what was gained on such a regime, as no evidence of improvement in the urinary findings took place in a year or more, and they seemed to be no better off than one who was fairly active for the same length of time. This question needs clarification but it would seem desirable to treat such cases as invalids as long as there is any evidence of disease of the kidney. At times this may be very indefinite as some of these cases go on to chronic nephritis.

Another question which frequently comes up in the later stage is that of attention to focal infection, especially the focus where infection seemed to initiate the process. This focus is frequently in the tonsils and we are faced with the problem of whether or not the tonsils should be removed, and, if so, when. Although the literature contains articles stating that such procedure is of doubtful value, clinical experience suggests the contrary, as follows: a patient we have followed for some months consistently shows abnormalities in the urine and an elevated sedimentation rate. He has a pair of large reddish tonsils. Every few months he comes in to say that he has a sore throat, examination of which shows no particular change from the previous visit; yet on these occasions his urine shows more albumin and, particularly, more red cells than at other times. Such experiences lead us to feel that foci of infection should be removed at the earliest reasonable time, say after the clinical state has been unchanged for a month.

In conclusion, we would like to draw your attention to a procedure which has no bearing on the treatment of acute nephritis, but may be useful in a somewhat similar state, i. e., peritoneal irrigation in cases where acute kidney shut-down has been provoked by transfusion reaction or sulfonamide poisoning. In a few cases irrigation of the peritoneal cavity with saline or other physiological solution has served to wash from the blood the toxic products which cannot be eliminated by the kidney and thus the patient has been kept alive sufficiently long for the kidney to recover and resume its normal function.

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1947 Edition of Parergon.

Parergon (work by the side of work) is Mead Johnson & Company's picture book of artistic works by physicians.

The current edition is a book of 208 pages and shows 1100 examples of creative art by contemporary physicians.

This book is available without charge only to physicians upon request of Mead Johnson & Company, Evansville 21, Indiana.

Popular Profession with German Students

More German university students want to take up medicine than any other profession, according to the Berlin correspondent of *The Journal of the American Medical Association,* writing in the October 18 issue of that publication. He states that this is particularly true in the American and Russian zones of occupation.

The number of registered medical students in the four zones is: American, 10,714; British, 6,430; French, 2,887; and Russian, 3,336 plus an unknown number from Rostock and Greifswald which do not give official figures.

At present however, the writer reports that many universities do not admit first year medical students. The chief difficulties are (1) the destruction of many of the university buildings, institutes, clinics and laboratories; (2) a shortage of textbooks, with those of a generation ago often the best available sources of instruction; (3) lack of housing.

"The percentage of women students is higher in the Russian zone than in western Germany," the correspondent adds. "In Berlin, for example, women constitute 40 per cent of the total, with an absolute majority at the Medical and Philosophical Faculties. In 1932 only one fourth of the students were women."

XUM

STREPTOMYCIN IN TUBERCULOSIS*

W. E. ROYE, M.D.,†
Richmond, Virginia.

The series of cases published by Hinshaw in the *J. A. M. A.*, November 30, 1946, is a complete summary of our knowledge to date.

In September, 1946, the American Trudeau Society and various governmental agencies began controlled observations of the use of streptomycin in clinical tuberculosis. All concerned have repeatedly warned that the drug is still in the experimental stage. A signed consent should be obtained from the patient prior to using the drug, and the study should have full laboratory control.

Preliminary unpublished data is presented to show some of the early observations in these controlled studies nationally as presented at a Conference in December, 1946.

Pulmonary Tuberculosis: (135 cases)

All cases presented were treated with 1.8 grams of streptomycin daily and were selected because of the high exudative component of the disease.

24% progressed better than is usually expected under bed rest.

59% did as expected with bed rest alone.

4% became worse.

The balance were discarded because opinions were too variable to be significant statistically. Results in empyema were poor. Fibrotic thick-walled cavities were not closed. No definite conclusions as to dosage and length of treatment have been reached. Different series varying from 90 to 120 days will be tried. Dosage varying from 1 to 3 grams daily is being observed.

Tuberculous Meningitis: (27 cases)

12 cases are living. Only one meets the criteria of complete cure. Intrathecal treatment on this case was continued until the 142nd day. Relapses when treatment was stopped in 40 to 75 days were reported.

The dosage is .1 gm. intrathecally daily combined with 1.2 to 4 gms. intramuscularly daily. A level of 20-30 micrograms per cc. was reached in the spinal fluid.

Soft Tissue Sinuses: (12 cases—55 sinuses)

When combined with excision or incision and drainage the sinuses have all closed and apparently remained closed. This does not apply to infected chest walls from empyema.

Tracheo-Bronchial Tuberculosis: (14 cases)

All cases fully healed in less than 3 months and have apparently remained healed. This is almost too optimistic to be true. Considerable attention is being placed on a large series at present to verify the results. Dosage was 2.5 grams intramuscularly and .5 gm. by aerosol daily.

Tuberculosis of the Larynx:

.5 gram has been used by aerosol, atomizer, and powder insufflations. Only about 50% were aided. Further study will be made by combining the above with intramuscular injection.

Gastro-Intestinal Tuberculosis: (Incidental to some of the pulmonary cases)

Favorable results have been obtained by combining the oral and intramuscular routes.

Bone Tuberculosis:

No facts of value to date.

G. U. Tuberculosis:

Series is not advanced enough to report.

LABORATORY STUDIES

It is essential that all cases have full laboratory control. Some of the tests are new and ingredients difficult to obtain. It is best that the laboratory have some advance practice in these tests.

The minimum requirements include stereoscopic x-rays, positive culture growing, urinalysis, NPN, urea clearance, complete blood counts, sedimentation rates, audiograms, caloric stimulation tests for vestibular damage, nude photographs, and congo red tests if amyloidosis is suspected.

Dilution of Streptomycin:

4.5 cc. of saline or distilled water to 1 gm. of drug. Any precipitate is allowed to remain in the ampule. Novocaine is added to the syringe but not to the ampule. With most lots the average patient will not need novocaine if the sites of the injection are rotated.

*Presented at the Symposium on Therapy, February 18-19, 1947, Medical College of Virginia, Richmond, Virginia.

†Chief of Section on Tuberculosis, McGuire Veterans Administration Hospital, Richmond, Virginia.

TOXIC REACTIONS

Loss of hearing and progressive kidney irritation are regarded as irreversible and necessitate the cessation of the drug. A serum streptomycin level above 50 micrograms per cc. is regarded as evidence of serious kidney damage.

Exfoliative dermatitis, purpura, and bone marrow depression have been reported.

Vertigo, eosinophilia, fever, nausea, and flushing of the skin occur during the treatment of nearly every case.

The damage to the vestibular apparatus is permanent. Most of the patients develop a compensatory mechanism. The occasional patient that does not develop the compensatory mechanism is a serious problem.

CONCLUSIONS

Streptomycin is a dangerous experimental drug. The physician should use it only with full laboratory control. The patient should sign a statement that he understands the limitations and the possible permanent damage.

At the present time, it is not justifiable to use streptomycin on any patient who is doing well under standard methods of treatment.

Doctor Gets Smaller Part of Dollar.

The proportion of national income spent for medical services actually has declined since 1940, according to a study made by Frank G. Dickinson, Ph.D., Director of the Bureau of Medical Economic Research of the American Medical Association. That this has happened in spite of the climbing cost of medical care and increased demand for medical services is emphasized in an editorial in the September 27 issue of *The Journal of the American Medical Association.*

The editorial states:

"Costs of medical care as a whole tend to move countercyclically; in a depression such costs comprise a larger share of total consumer expenditures and national income than they do in prosperous times. In a period such as the present, the trend is toward more furious inflation and lower relative expenditures for medical care. This is borne out by Dr. Dickinson's figures—medical care took 4.4 per cent of total consumer expenditures in 1932 and 1933, then the share trended downward to 3.9 per cent in 1946. Necessities always loom more important in depression; luxuries, in prosperity. But all evidence indicates that, case for case, medical care costs more each year—particularly where hospital care is concerned. Thus the decline in relative importance of medical care expenditures has occurred in spite of climbing costs of specific treatments and an over-all increase in demand for medical services arising from the aging population, the high birth rate and popular education in health which lessens fear of hospitals.

"The declining percentage of income expended on medical care is paralleled by increasing proportions spent on alcoholic beverages, recreation, personal care and jewelry; these items in the budget were selected by Dr. Dickinson not for moral reasons but for comparability in the size of total expenditures.

"Physicians will be interested to learn that their share of the medical care dollar has declined from 32 cents in 1929 to 27 cents in 1945. Part of this decline may have been caused by the absence of those physicians who were in the armed forces during 1945. The gap was filled chiefly by increases in the share of the medical care dollar spent for drugs."

The Leslie Dana Gold Medal,

Awarded annually for outstanding achievements in the prevention of blindness and the conservation of vision, was presented this year to Dr. Frederick H. Verhoeff, of Boston, Mass., during the Faculty Luncheon of the American Academy of Ophthalmology and Otolaryngology, in Chicago, October 16. Dr. Verhoeff was selected for this honor by the St. Louis Society for the Blind, through which the medal is offered by Mr. Leslie Dana of St. Louis. This highly prized token of recognition in the field of public health is given upon the recommendation of the Association for Research in Ophthalmology.

Dr. Verhoeff is Professor Emeritus of Ophthalmic Research at Harvard Medical School and Consulting Chief of Ophthalmology at the Massachusetts Eye and Ear Infirmary.

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A CASE OF PROGRESSIVE BILATERAL BULLOUS EMPHYSEMA COMPLICATED BY CHEST TRAUMA*

HORACE ALLEN ALBERTSON, M.D.,
and
CHARLES H. PETERSON, M.D.,
Roanoke, Virginia.

We are reporting our one case of "progressive bilateral bullous emphysema" because it confused us in the interpretation of roentgenograms taken of a patient following chest trauma.

"Progressive bilateral bullous emphysema" is an entity distinct from the emphysema of the bullous type usually seen. In 1946 Allison Howe Price and George Teplick[1] of Jefferson Medical College collected 13 cases from the literature and reported 8 of their own. In their article they state that in the usual type of bullous emphysema any part of the lung may be involved, but in "progressive bilateral bullous emphysema" the disease usually begins in the apices and proceeds downward until in extreme cases both upper and lower lobes may be replaced by large cyst-like areas.

They further state that the disease is apparently limited to men and is usually seen after the second decade. The usual history is that of cough, slowly increasing dyspnea, recurrent respiratory tract infections, cachexia, and recurrent asthma-like attacks. Death usually occurs from intercurrent infections or when insufficient pulmonary tissue is left to carry on normal respiratory exchange.

Our patient was a 53 year old white male who was brought to the emergency room of the Jefferson Hospital around 9:00 P. M. the night of 4 November 1946. His story was that he had been attacked on the street. His assailant knocked him down and then kicked him in the left side of his chest. His past history was relevant in that for an indefinite length of time he had had a cough due to what he called a "bronchial condition".

When seen in the emergency room he had severe pain in the left side of his chest which was exaggerated by respiration and coughing. On examination it was found that he had marked tenderness over the 5th and 6th ribs in the axillary line on the left side. Breath sounds were diminished over the entire left lung, but it was difficult at the time to say whether the diminution was due to "splinting" or to some other cause. The percussion note was thought to be slightly hyperresonant. His temperature was 98.6, pulse 130, respiration 24. A tentative diagnosis was made of fractured ribs and possible traumatic pneumothorax of the left lung. Adhesive strapping of the lower left chest was done in the emergency room and he was admitted to the hospital.

In spite of moderate doses of morphine he continued to have pain. The pain was worse when he coughed. He attributed his cough to the previously mentioned "bronchial condition".

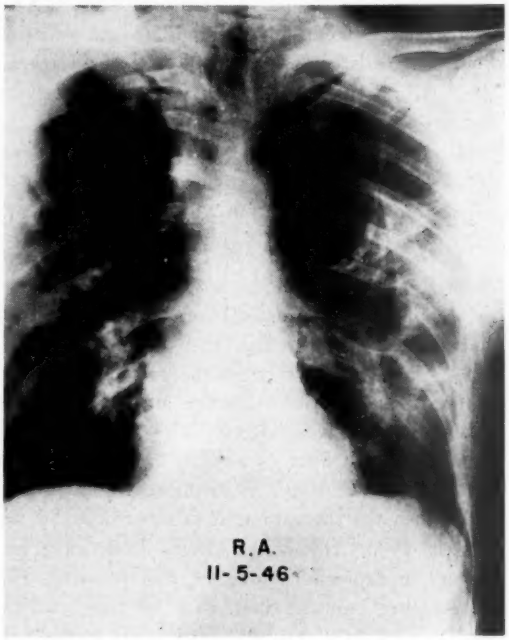

Fig. 1.

The next morning a portable x-ray of his chest was ordered (Fig. 1). It showed what we thought was a bilateral area of pneumothorax immediately adjacent to the mediastinum. The appearance was

*From Departments of Surgery and Roentgenology, Jefferson Hospital, Roanoke, Virginia.

symmetrical on each side. Both lungs were somewhat compressed with scattered areas of infiltration throughout. The left fourth, fifth and sixth ribs were fractured in the axillary line. No other definite rib injury was demonstrated. There was no free fluid in the chest. Laboratory work done this A. M. showed 14.35 gms. of Hb. and 15,750 Wbc; urine was essentially negative except for a trace of albumin. Blood Wassermann and Kahn were positive.

On his second hospital day his respirations became more labored and he was put in an oxygen tent. From time to time he expectorated a small amount of bloody sputum. His third and fourth hospital days were spent propped in bed in the oxygen tent, complaining of shortness of breath and pain in his left chest. His respiration varied between 20 and 40 and his pulse between 110 and 136. His fourth day he was mentally confused from time to time.

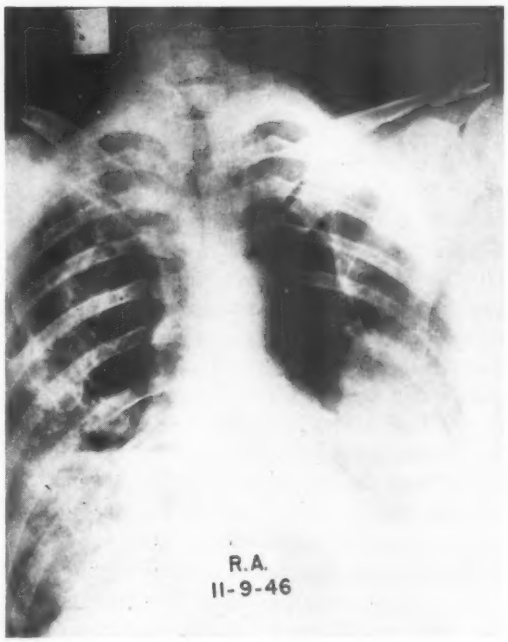

Fig. 2.

On his fifth day his temperature was elevated slightly and he was cyanotic from time to time in spite of tent oxygen. The night of the fifth day he became very restless and thrashed about in his oxygen tent despite morphine, sodium amytal and rectal paraldehyde given at various times throughout the night.

An emergency portable x-ray of his chest was taken around 10:15 A. M. the sixth hospital day (Fig. 2). This showed an increase in the amount of air on both the right and left sides. There was a greater compression of the lungs.

Shortly thereafter a needle aspiration of the left thorax was done. The needle was inserted just medial to the mid portion of the left scapula. Air was found under pressure and was released. His restlessness was relieved and his cyanosis cleared up for a short while. Because of the above relief an intercostal trocar was inserted in the same place as the aspiration had been performed. The trocar was strapped in place with adhesive. The patient died 50 minutes later.

The chief organ of interest at autopsy was this man's lungs. On opening the pleural cavity on the right it was found that air escaped under pressure with a hissing noise. Both apices were stuck to the parietal pleura with adhesions. The apices were freed and the heart and lungs were removed from the thoracic cavity in a block. The left lung was about 25 per cent collapsed. The superior part of the left upper and lower lobes was replaced or made up of two large emphysematous bullae which were about the size of oranges. The entire lung was dark purple in color and had many doughy areas. On cross section of the lung, numerous walnut-sized, doughy feeling, purplish areas were conspicuous. In the bronchi there was thick grayish tenacious sputum. The walls of the bronchi revealed nothing remarkable.

On opening of the large emphysematous bullae it was found that the bullae were divided into numerous partitions by thin, tough fibrous strands. There was also a small amount of straw-colored fluid in the left lung. On the lateral surface of the upper lobe of the left lung was a well circumscribed raised area about 2 to 3 cm. in diameter. It was hard and knotty.

The right lung was about 75 per cent collapsed. At the apex there were 4 emphysematous bullae, one about the size of a duck egg, another about the size of a hen egg and several the size of a walnut. Attached to or a part of the posterior, superior portion of the right lower lobe were several walnut-sized bullae. The lung was deep purple in color and

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doughy in consistency throughout. The bronchi were found with a thick, purulent, grayish material.

The examination of the heart showed normal pericardium; no fluid in the precordial sac. The right and left ventricles were normal. The right and left auricules were not remarkable. The valves were all normal. The arch of the aorta showed marked athero-sclerosis.

The microscopic picture of this man's lungs showed alveoli which were filled with fluid and a large number of polys.

It is our opinion that this man had "progressive bilateral bullous emphysema" which was complicated by a trauma to his chest severe enough to fracture three ribs. If this patient had not entered the hospital as a traumatic case we believe the x-ray diagnosis would have been obvious. One of the members of our staff suggested "progressive bilateral bullous emphysema" when he saw this man's film but he was overruled by the majority of us who knew the patient's history. This man came in as an emergency case following trauma to his chest. Cough and "bronchial trouble" were just an additional part of his history. This is why we were looking for and attempting to interpret his plates on the basis of trauma alone, which autopsy proved could not be done.

SUMMARY

We have added to the literature one case of "progressive bilateral bullous emphysema"; also we have attempted to show how this entity may lead to confusion in the interpretation of x-rays of the chest in patients who have had chest trauma.

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"Nose Drops".

Those who have the habit of using "nose drops" day after day are doing themselves more harm than good, says R. Wesley Wright, M.D., Palo Alto, Calif., in the current *Archives of Otolaryngology*, published by the American Medical Association.

Dr. Wright cites the cases of patients who have suffered from nasal congestion for as long as four years before discovering that the nasal drops that gave them temporary relief were actually the cause of the discomfort. Sometimes more serious conditions were found, too: loss of the sense of smell; destruction of the nasal membrane. In all the cases that he reports the nasal congestion was relieved from 24 hours to a few days after discontinuance of the medication, although in at least one case the sense of smell had not yet returned.

"Vasoconstrictor" is the medical name given to compounds that cause constriction of the blood vessels, thus producing less swelling in the nose and giving a larger opening for the passage of air. But, says Dr. Wright, the use of synthetic vasoconstrictors is likely to bring about nasal symptoms which are often unrecognized as those of drug sensitization. Every time the effects of the drug wear off, the swelling returns to produce even more nasal congestion than before.

"The patient comes complaining of nasal congestion which is constantly present," he writes. "Nasal drops, whichever are being used, will open the nasal passages well, and the breathing space then seems normal, but the congestion returns in about three hours. . . . The dependence on the medication is such that the medicament is carried at all times by the patient. . . .

"The history of the onset of the condition for which the nasal medicament was used varies. Usually the condition was an acute cold or a recurrent attack of chronic sinusitis. In other instances the onset was the nasal congestion associated with pregnancy. . . . The patients were given drops to use until term, but the nasal congestion presisted. During colds they were given drops to use, or obtained them, and though the discharge usually ceased, the patients assumed that the condition had becme sinusitis or some other chronic nasal condition."

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REVERSAL OF CARDIAC HYPERTROPHY BY EXCISION OF POPLITEAL ANEURYSM

RUDOLPH ANTONCIC, M.D., F.A.C.S.,*
Hamilton, Ohio

This report gives the case history of a patient with a traumatic popliteal aneurysm and a discussion of the physiology of the cardio-vascular changes before and after treatment.

J. F., a seventeen year old farmhand, was admitted to Pulaski Hospital on June 2, 1945, with a 22 caliber rifle bullet wound of the right thigh. The shooting had occurred about two hours before admission and several turns of baling wire had been applied as a tourniquet at mid-thigh. The boy showed no evidence of shock. All pertinent findings were limited to the right lower limb. The foot and especially the toes were purple black. Sensation was absent in the toes. The wound of entrance was in the lateral thigh about 4 inches above the knee. The bullet had traversed the thigh without fracturing the femur (x-ray) and emerged medially just proximal to and slightly inferior to the adductor tubercle.

The baling wire was immediately removed; the wounds were debrided and the regional skin cleansed with soap, water, ether and merthiolate. A snug dry dressing was applied. The patient was given 1/75 grain of atropine sulfate intramuscularly to inhibit reflex arterial spasm due to trauma (de Takats). Antitetanus and gas injection was administered and prophylactic oral sulfadiazine prescribed. The patient was put to bed with the affected limb in a slightly dependent position to take full advantage of the venous hyperemia. The color of the foot had improved to a dusky blue. The dorsalis pedis and posterior tibial arteries were not palpably pulsating on the right side. There was a slow but definite return of color to areas blanched by digital pressure. Six hours later the foot was only moderately cyanosed.

Seven days after the injury the exit wound showed a scant purulent discharge and a diffuse pulsating tumor measuring 8x5x3 cm. was noted. A loud harsh bruit with systolic amplification was audible over the mass and could be heard transmitted through the patella. There was a palpable thrill with systolic accentuation. The dorsalis pedis and posterior tibial pulsations were absent on the right. The peripheral veins were slightly distended and the toes were cooler than on the left. Slight edema was present. Five days later the wound was dry and pressure obliteration of the aneurysm caused the pulse to drop from 66 to 54 per minute and the blood pressure to rise from 110/44 to 116/60. On obliterating the aneurysm the foot rapidly became cyanotic. The blood pressure and pulse changes and the systolic accentuation of the bruit are considered pathognomic of arteriovenous fistula.[1] A teleroentgenogram on the 9th day after injury showed the heart to be of normal size (fig. 1). The patient

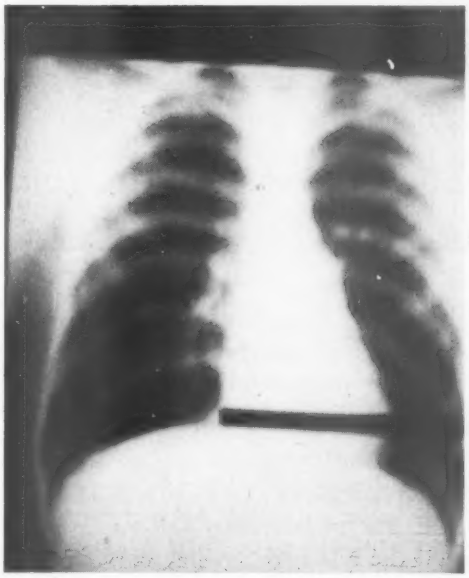

Fig. 1.

was discharged 12 days after admission and then was seen every two weeks and studied for the development of collateral circulation. The patient's brother compressed the aneurysm manually, using a felt pad two or three times daily and increasing from 1 to 20 minutes. As shown many years ago

*Recently of Pulaski, Virginia.

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by Matas, such systematic obliteration of the aneurysm will stimulate the development of collateral circulation.

The patient was readmitted on August 27, 1945 (12 weeks after the injury). At this time compression of the aneurysm for 30 minutes caused only a slight cyanosis of the foot. The Moschcowicz hyperemic test indicated adequate collateral circulation. The teleo on August 27, 1945, showed moderately severe cardiac hypertrophy (fig. 2). After three days of bed rest the patient was operated upon.

Fig. 2.

Operative Technique.—With the knee flexed and the thigh abducted and externally rotated the popliteal space was approached from the medial thigh. No tourniquet was used in order that the distended vessels might be more easily identified. The sartorius muscle and adductor magnus tendon were mobilized and the aponeurotic roof of Hunter's canal opened. The femoral artery and vein were then isolated and held with tape just above the site of entrance into the adductor magnus. The popliteal artery and vein deep in the fossa distal to the aneurysm were similarly under-run with tape, thus controlling the major vessels. The arteriovenous aneurysm involved the upper half of the popliteal vessels. The popliteal artery and vein were then isolated proximally and distally to the fistula as close to the aneurysm as feasible, saving every collateral possible. Quadruple ligation of the proximal and distal popliteal vessels was done, using heavy silk ligatures on the artery which was emptied before being doubly tied. The arteriovenous fistula and a 1 cm. aneurysmal sac coming from the medial side of the artery at the level of the arteriovenous communication were dissected out of the muscle bed, ligating a few small vessels that entered the sac from below. The entire aneurysm consisting of small segments of popliteal artery and vein proximal and distal to the fistula and the small sac mentioned above were excised. The fistula measured 5 to 6 millimeters in diameter. The wound was closed and elastic compression applied. The post-operative blood pressure was 138/56, indicating that the increased peripheral resistance occasioned by the tying of a large artery plus the shunting of the volume of blood going through the fistula into the general circulation

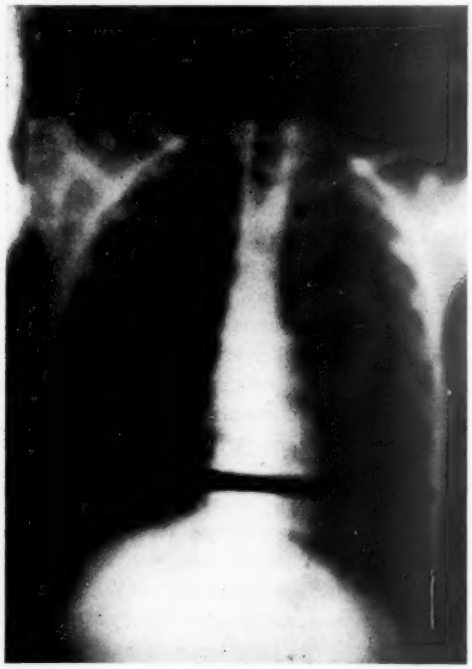

Fig. 3.

raised the systolic blood pressure. Several hours later the toes were slightly cyanotic but there was a prompt return of color after digital blanching and the skin was warm. On the third post-operative day the operated limb appeared quite like the normal one except for slight edema. The wound healed

nicely and the patient was discharged 21 days after admission. The final teleo 20 days after excision of the aneurysm showed the heart to be even smaller (fig. 3) than that shown in figure 1, suggesting that slight cardiac enlargement had already occurred within a few days following the formation of the fistula.

Circumferential measurements of the legs and thighs at fixed points from the patella gave the following results:

Before operation (in inches)	19 days after operation
1. calf 12½ r. calf 13	1. calf 12 r. calf 12
1. thigh 17½ r. thigh 18¾	1. thigh 17 r. thigh 16½

The increased volume of the limb with the aneurysm was decreased after operation so that the thigh measured two inches less in circumference. The control thigh showed a decreased circumference of ½ inch persumably due to atrophy of bed rest.

The patient was last seen 14 months after operation. There was no recurrence. The blood pressure was 122/60. The patient was doing farm work and had no complaints.

DISCUSSION

In the presence of a moderately large arteriovenous fistula cardiac dilatation occurs very quickly. In this patient the chest film showed a slight cardiac enlargement already present on the 9th day after the injury. Dilatation of the heart is part of the generalized dilatation of vessels comprising the short circuit of heart, artery, fistula and vein.[2] The heart hypertrophies in response to the increased volume of blood going through it per unit of time. In a large arteriovenous fistula 50 per cent of the blood volume may in time be diverted from the general circulation, resulting in a decreased peripheral resistance. As the blood volume is restored in the general circulation to maintain the blood pressure the total volume going through the heart may be almost doubled.[3]

Compressing the fistula shunts the mass of blood going through the fistula into the general circulation and raises the blood pressure. The raised pressure in the carotid arteries stimulates the carotid sinus reflex which slows the heart via the vagus nerve.

Delaying the operation for 3 to 6 months allows for the development of adequate collaterals, absorption of the hematoma, subsidence of infection and the occasional spontaneous cure of a small arteriovenous fistula. If the operation is delayed too long the cardiac hypertrophy may go on to cardiac failure.

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133 North Second Street

Preventing Runaway Epidemics.

Since the end of the second World War there have been no runaway epidemics in Europe, and only one disease, cholera, has reached epidemic proportions in the Far East.

In an article in the September issue of *Hygeia*, Virginia Rishel, Washington, D. C., who is on the staff of UNRRA, calls this an achievement which can be credited to "one of modern history's happiest triumvirates: the new methods developed by medical science between the wars, their bold use by the Allied armies and the now defunct UNRRA— and luck."

"The new products," Miss Rishel writes, "included DDT, death warrant for insects, and sulfas and penicillin. DDT stopped typhus dead in its tracks and reduced malaria in Greece to its lowest incidence since classical times. The sulfas and penicillin spectacularly cured and thus curtailed the spread of dysentery, venereal disease and a plethora of other infections.

"The health staffs of the Army and UNRRA went into action before the guns ceased firing. The Army gave medical care to the populations of the villages they liberated, and to the enemy countries they occupied. UNRRA set on their feet the health departments of 13 of the world's most devastated and disorganized invaded nations, and advised them how best to use both the new and the familiar supplies that began to arrive. UNRRA's professional medical staff was tiny but its supplies were a cornucopia of health—200,000 long tons of everything from chlorine to x-ray apparatus, from hypodermic needles to hospital beds.

XUM

PUBLIC HEALTH

L. J. ROPER, M.D.,
State Health Commissioner of Virginia

The report of the Bureau of Communicable Diseases of the State Department of Health for September 1947, as compared with the same month in 1946, and for the period of January through September 1947, compared with the same period in 1946, is as follows:

	Sept. 1947	Sept. 1946	Jan.-Sept. 1947	Jan.-Sept. 1946
Typhoid and Paratyphoid	27	12	98	97
Diarrhea and Dysentery	640	198	4,265	2,323
Measles	83	57	7,522	12,888
Scarlet Fever	42	94	936	2,175
Diphtheria	11	51	167	343
Poliomyelitis	55	19	114	87
Meningitis	2	12	85	180
Undulant	11	7	63	49
Rocky Mountain Spotted Fever	8	13	62	90
Tularemia	7	5	46	50

POLIOMYELITIS IN VIRGINIA

Moderate increase in poliomyelitis incidence during the past ten week period has again attracted attention to the inherent problems of the disease. Many years of reporting experience available in the State Department of Health demonstrate that August and September, and secondarily July and October, are the months of highest prevalence. This fact is well illustrated by the following tabulation:

TWENTY YEARS OF POLIOMYELITIS IN VIRGINIA BY MONTH OF REPORT

	Jan.-June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total
			1927-1946					
Total Cases	335	627	948	795	484	251	92	3,532
Annual Average	16.7	31.3	47.4	32.7	24.2	12.5	4.6	176.6
Per Cent Distribution	9.5	17.8	26.8	22.5	13.7	7.1	2.6	100.0
			1947					
Total Cases	17	9	33	55	20.5*	10.6*	3.9*	149*

*Estimated. A total of 114 cases were reported through September 30, 1947, and 21 cases were reported through the fifteenth of October. A total of 135 cases have already been reported for 1947.

It is apparent that 49.3 per cent of the cases have been reported during August and September, with an additional 31.5 per cent in July and October, making a total of 80.8 for these four months. The estimated total cases for the last three months of 1947 are shown with the actual total number reported through September. Through the fifteenth of October a total of 21 cases have been reported, and this figure is in excess of the estimate for the month. This makes a total of 135 cases for the nine and one-half months.

The years of high prevalence are as follows: 1917, 1923, 1929, 1935, 1940 and 1944, and from this it may be noted that six year intervals separate the first four, a five year interval separates the fifth and sixth, and a four year interval separates the sixth and seventh. Undoubtedly the mass shifting of population groups into Virginia had much to do in lessening the cycle between outbreak or epidemic years. During 1944, the greatest year on record for poliomyelitis, a total of 756 cases were recorded and this was followed in 1945 by 335 cases.

The attack rates per 100,000 population by five year periods have varied from 4.3 to 9.4, with an average of 6.5. A total of 103 deaths have occurred in the 1,338 cases reported in the five year period 1942-1946, showing a case fatality rate per 100 cases of 7.7.

Geographic distribution of cases has shown concentration in the large city areas, with most scattered cases appearing centrally and in the western counties, and while incidence has been beyond expectation, the situation does not appear alarming.

CORRESPONDENCE

Care of the Tuberculous Should Have Legislative Appropriation.

Edwardsville, Va.
September 25, 1947.

TO THE EDITOR:

When the modern State Department of Health was organized in 1908, the first two objectives were to build and maintain a Tuberculosis Sanatorium and to equip and run a modern diagnostic laboratory. These are still the two branches of the Department that are most helpful to the general practitioner. Yet these are the services that have grown the least during the last decade.

Of what value is a county health unit or an x-ray clinic in finding cases of TB if our sanatoriums are not staffed so that we can send our early cases for treatment and hygienic instruction, and our far advanced cases for the protection of their family and friends?

Many of our ill patients are unable to pay for satisfactory laboratory tests and the laboratory can not give adequate service unless sufficient funds are appropriated to employ helpers and to enlarge its scope of services.

When the physicians of the state realized that hookworm was so prevalent and so readily treated when diagnosed, and that a definite diagnosis could be made only in a laboratory, Dr. Ennion G. Williams contacted the local physicians to ask them to see their representatives in the Senate and House of Delegates to ask them for an appropriation for the Health Department. This many of us did, so effectively that the Legislature appropriated several times as much as Dr. Williams expected to get or even asked for.

If our physicians would do the same this year our sanatoriums and laboratory would again advance and become modern institutions.

B. B. BAGBY, M.D.

Apropos to the work done by Dr. Bagby in the fight on hookworm, while with the State Department of Health, is the following letter from Dr. S. Peachy Latane to his sister, wife of Judge C. B. Jones of King and Queen County (home of Dr. Bagby).

Charlottesville, Va.
October 10, 1906.

MY DEAR JULIA:

I have been up here attending the meeting of the State Medical Society. I have an hour or so to wait before my train tonight, and I must write you to tell you how Little Bathurst Bagby made the hit of the meeting.

You may have seen recent reports of the Government about the tropical anemia found in our Colonial possessions—chiefly in Puerto Rico. This anemia being due to an animal parasite—the hookworm—which gains entrance to the body through dew itch or ground itch in barefoot people. Well, to make a long story short, while some of us have suspected that many of the so-called chronic malarias of the extreme southern states are nothing more nor less than cases of hookworm infection, Bathurst Bagby has proved that we have it right here in Virginia. He worked his suspected cases up well, sent specimens to the Government laboratories in Washington, D. C., for confirmation, and prepared a paper on the subject. In addition, he had the enterprise to bring three cases all the way up here with him.

I saw him up here and found what he had; got every body I knew to come over and see his cases and worked up as much interest and anticipation over his paper as I could before it was read. Finally when he read it and showed his cases, the Society went wild. The members crowded up on the platform and gave him a regular ovation. He made the hit of the meeting.

Today when they came to elect officers, it occurred to me that he ought to have some recognition and I had him nominated as one of the vice-presidents. I had an older member nominate him and I seconded it. I thought that he would possibly be run in a third vice-president, simply as a matter of courtesy and compliment. Don't you know that before they knew it he was elected first vice-president!! Dr. Paul B. Barringer of the University of Virginia is president and Dr. B. B. Bagby, of King and Queen is first vice-president. Isn't that remarkable?

The truth of the matter is that the little chap looked so young and delicate and so nervy withal, the people voted for him without knowing what they were about. I am truly delighted—though how

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he would hold down the job in the absence of the President I don't see!!

He has been asked to stop in Richomnd and give his lecture and show his cases before the Medical College of Virginia. This is a great send off for him.

I thought you would be interested to know of it all.

Now all the little "dirt eaters" can be diagnosed and cured!

I have had a very pleasant visit here. I have been staying with John Staige Davis and have seen a good many old friends and acquaintances.

(signed) S. P. LATANE

WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF VIRGINIA

President.....MRS. J. L. DECORMIS, Accomac
President-Elect.....MRS. R. M. REYNOLDS, Norfolk
Recording Secretary.....MRS. M. H. HARRIS, West Point
Corresponding Secretary MRS. HOLLAND TROWER, Eastville
Treasurer.....MRS. REUBEN SIMMS, Richmond
Parliamentarian...MRS. E. LATANE FLANAGAN, Richmond
Historian.....MRS. H. A. LATANE, Alexandria

Report of President.

Today the Woman's Auxiliary to the Medical Society of Virginia begins a new year, a year of hope and anticipated accomplishments.

To me you have given the responsibility and honor of being your new president. This responsibility I accept with a deep feeling of humility with the hope that through Him who doeth all things well I may be given physical strength and wisdom to serve you faithfully and well.

Here I would like to pay tribute to my predecessors who have been an inspiration to all of us and who have so ably guided the auxiliary through the past years.

Our purpose to serve as an auxiliary to the medical profession is accomplished through the activities of the officers and all the committees. Upon each auxiliary member rests the responsibility of furthur extending these activities. It is our desire to include all eligible women in our membership. In joining the medical auxiliary one does not add so many duties to an already crowded life, but receives guidance in a privilege and responsibility that we as doctors' wives already have.

The Bulletin, our national auxiliary publication, gives official and timely information, and is helpful in formulating plans and activities. Our national president has urged that we increase the circulation this year. It is edited for us at great time and expense, so let us show our appreciation by being subscribers.

Hygeia, published by the American Medical Association and edited by Dr. Fishbein, is filled with authentic information on health problems. The articles are written in terms understandable to the layman. Shall our goal be "*Hygeia* in every high school in Virginia"? If we subscribe to and read *Hygeia* and *The Bulletin* we will become better informed and more interested in the work of the Auxiliary and the advancement of health and health education.

It is vitally important that we as doctors' wives be well informed in order that we may take an important part in discussions and actions on health problems. However all activities with respect to health defense must be approved by the state and county advisory council.

Public Relations is a term that we hear used so much these days, and it has become a very important factor in our auxiliary work. One of the doctors at the Chicago Conference in December said that public relations was a complicated way of saying making friends. To make friends I think a sense of humor is essential along with warmth, tolerance and an easy approach to people. Our handbook tells us we must consistently and constantly promote such educational activities as will bring about better understanding between the medical profession and the public with respect to their common problems.

We are urged to help in the recruitment of nurses as there is a definite and alarming shortage of nurses in the nations' hospitals. Four hundred eighty five thousand six hundred graduate nurses will be needed in the coming years, some one hundred forty thousand less than the estimated probable supply.

Your president heartily recommends the philanthropic work of the past: the Leigh-Hodges-Wright Memorial bed fund, the Jane Todd Crawford Memo-

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rial fund, Cancer Control and last, but very important, Child Health and Welfare. If the world moves forward on the feet of little children, then to us is given the task of helping to make a healthier, better world. As I see it, our calling is a glorious blessing but it is also a tremendous responsibility. Let us be diligent with the opportunities placed in our hands for fulfillment.

MABEL LEWIS DECORMIS
(MRS. J. L.)

New Officers of State Auxiliary.

At the 25th annual meeting of the Auxiliary to the Medical Society of Virginia in Roanoke, October 14, Mrs. J. L. DeCormis of Accomac succeeded to the presidency, and Mrs. R. M. Reynolds of Norfolk was named president-elect. Other officers elected at this time were: Vice-presidents, Mrs. Andrew G. Shetter, Richmond; Mrs. O. Anderson Engh, Alexandria, and Mrs. Herbert C. Jones, Petersburg; recording secretary, Mrs. M. H. Harris, West Point; corresponding secretary, Mrs. Holland Trower, Eastville; treasurer, Mrs. Reuben F. Simms, Richmond; parliamentarian, Mrs. E. Latane Flanagan; and historian, Mrs. H. A. Latane, Alexandria. The directors will be Mrs. J. E. Hamner, Petersburg, Mrs. William Lett Harris, Norfolk, and Mrs. P. M. Chichester, Richmond.

The Annual Report of the retiring president, Mrs. J. E. Hamner, Petersburg, will appear with the minutes of the Medical Society of Virginia in December.

Richmond

New officers of the Auxiliary to the Richmond Academy of Medicine, installed at the September meeting, are: President, Mrs. Luther Brawner; president-elect, Mrs. George Vaughan; vice-president, Mrs. Thomas Wheeldon; treasurer, Mrs. Edward Ray; corresponding secretary, Mrs. Benjamin Sheppard; recording secretary, Mrs. Gilman Tyler; historian, Mrs. Edwin Bryce; and parliamentarian, Mrs. E. Latane Flanagan. The following are chairmen of standing committees: social, Mrs. J. H. Scherer; membership, Mrs. J. F. Blades; publicity, Dr. Matilda Chalkley; public relations, Mrs. P. E. Schools; personal relations, Mrs. R. F. Simms; and year book, Mrs. W. A. Young.

BOOK ANNOUNCEMENTS

Physician's Handbook. By JOHN WARKENTIN, Ph.D., M.D., and JACK D. LANGE, M.S., M.D. Fourth Edition. University Medical Publishers, Chicago, Illinois. 1946. 282 pages, Cloth. Price $1.50.

Hospital Care in the United States. A study of the Function of the General Hospital, Its Role in the Care of All Types of Illness, and the Conduct of Activities Related to Patient Service, with Recommendations for Its Extension and Integration for More Adequate Care of the American Public. Commission on Hospital Care. New York, The Commonwealth Fund, 1947. xxiv-631 pages. Cloth. Price $4.50.

Advances in Pediatrics. Volume II. Editorial Board: S. Z. Levine, Cornell University Medical College, New York; Allen M. Butler, Harvard Medical School, Boston; L. Emmett Holt, Jr., New York University, New York; and A. Ashley Weech, University of Cincinnati, Cincinnati. Interscience Publishers, Inc., New York, 1947. x-409 pages. Illustrated. Cloth. Price $6.75.

The Practical Nurse. By DOROTHY DEMING, R.N., Consultant in Public Health Nursing, Merit System Unit, American Public Health Association; etc. New York, The Commonwealth Fund, 1947. viii-370 pages. Cloth. Price $3.00.

A History of the American Medical Association 1847 to 1947. By MORRIS FISHBEIN M.D. with the Biographies of the Presidents of the Association by Walter L. Bierring M.D. And with Histories of the Publications, Councils, Bureaus and Other Official Bodies. Philadelphia & London, W. B. Saunders Company 1947. xvi, 1226 pages. Illustrated. 24.4 cm. Price $10.00.

This is an encyclopedic work and consequently lacks uniformity of literary merit. Unfortunately it begins with an account of Nathan Smith Davis, M.D., A.M., LL.D. by Nathan Smith Davis III, M.D. a conglomeration of family troubles and the efforts of "Papa Davis" to keep the A. M. A. on its proper course. "Dr. Davis was known to hundreds who had only seen him walking back and forth regularly." Thousands who will read this biography will get no better acquainted with him. He must have been a man worth really knowing. One gets the impression that Nathan Smith Davis almost singlehandedly founded the A. M. A., started the Journal and established the Judicial Council. Succeeding pages of the History dispel this impression somewhat.

The play-by-play development of the A. M. A. in the form of accounts of the annual meetings appeared serially in the Journal. This reviewer enjoyed reading them as they appeared and is glad to have them in a convenient form for reference.

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As Nathan Smith Davis' influence waned with age, a "dictator" in the person of George H. Simmons, took charge. Dr. Simmons was a great organizer but in his fight against patent medicine and quackery he made many enemies who did not hesitate to circulate scandalous stories about him. Dr. Fishbein has treated this chapter sympathetically and removed much of the mystery that was attached to his memory. The chapter on Libel Suits of the American Medical Association makes interesting reading. Dr. Bierring's biographies of the Presidents of the A. M. A. are quite attractive. Each sketch is accompanied by a portrait and some are quite good. The one of Dr. Thayer is terrible. Dr. Thayer's wonderful personality which you felt as soon as you came in sight of him, did not register on the photographic film, but it would seem that a better portrait of him could be found than the one that was selected.

The A. M. A. was founded primarily to improve medical education. Dr. Bierring tells us that the principal theme in every presidential address throughout this hundred years has been some phase of medical education. However the Association has had other interests and these are described by those who know most about them. The library was stored for years in the garret of the Smithsonian Institute until in 1895 it was given to the Newberry Library which in turn gave it to the John Crerar Library in 1907. Four years later Dr. Simmons started a working library in the A. M. A. headquarters building with a trained librarian, Miss Helen Hutchinson, who not only established loan collections but took over the indexing of the associations Journals. This latter activity grew into Quarterly Cumulative Index to Current Medical Literature and finally the Quarterly Cumulative Index Medicus. There are chapters on the various councils and Bureaus of the Association and one on its Publications. Each of the 132,224 members of the A. M. A. should have this handbook so as to realize what a wonderful association he belongs to. The A. M. A. has always been a fighting organization. At first there was its fight against proprietary medical schools and then its fight against proprietary medicines and quacks and now its fight against politically controlled medicine. These fights created powerful enemies that have sometimes undermined the faith of the doctors themselves. The first two "fights" were primarily for the benefit of the people. The last is for the benefit of the people as well as medicine itself. Every friend of medicine should read this book in order to gain a background of facts to aid him in the present crisis and in shaping the course of organized medicine in the future.

M. P. R.

Medicine in the Changing Order. Report of the New York Academy of Medicine Committee on Medicine and the Changing Order. New York, The Commonwealth Fund. 1947. xviii-240 pages. Cloth. Price $2.00.

This report represents a four year study conducted by 33 outstanding physicians and 17 representatives of allied professions and lay persons. Their object was to find out how economic and social conditions and changes are affecting health and medical practice in this country and what must be considered in planning for the future.

Enough of the past is given to understand how certain present conditions came about. In addition to medical practice this study covers medical education, hospital facilities, dental care, nursing service, public health service and medical research.

The fallacy of thinking that the problem of medical care is that of the cost is corrected by pointing cut that there are many problems involving differences in population density, social and educational conditicns as well as economic factors.

Compulsory health insurance is not approved at the present time, nor is "any other form of prepaid, full-coverage insurance to be applied as suitable for all sections of the country at the present time." Medical services paid by an insurance fund tempts the patient to demand more attention than he requires, and tempts the practitioner to add to his income by rendering unnecessary service.

The present system of state board licensure is believed to keep the medical curriculum rigid and inhibit progressive changes.

This report appears objective and is a valuable presentation of information. It is information that medical and lay people both need as background for considering medical and health problems in their own communities.

RAYMOND KIMBROUGH.

EDITORIALS

Our New President

THE Medical Society of Virginia is indeed fortunate in its choice of a president for the coming year, a year which will be most important in the history of our Society.

Dr. Guy R. Fisher graduated from the Medical College of Virginia in 1912 and served his internship at St. Elizabeth's Hospital in Richmond. He then located in New Hope, Virginia, his home town, where he engaged in general practice until 1919 when he went to New York and specialized in diseases of the Eye, Ear, Nose and Throat. Returning from New York, he began the practice of his specialty in Staunton in 1922 and has had a most successful practice there since that time. He is a diplomate

GUY ROTHWELL FISHER,
President, Medical Society of Virginia

of the American Board of Otolaryngology and his basic training in general practice has given him an excellent perspective for his specialty.

Dr. Fisher has held many high honors both in medical and lay circles. He is a past president of the Augusta County Medical Association, the Medical Society of the Valley of Virginia, and the Virginia Society of Ophthalmology and Otolaryngology. For many years he has been a regular attendant at the sessions of the Medical Society of Virginia and has done excellent work on many of its important committees.

In addition to his Medical Society activities he has been one of the leading Masons of Virginia and is Past Illustrious Potentate of Acca Temple. He has served as

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president of the Staunton Kiwanis Club, as a delegate to a national political party convention, and is now National President of the Circus Saints and Sinners of America, Inc. He has given freely of his time and has been in great demand to address various civic, religious, and educational groups, and has been most public spirited in his active support of all worthwhile charities.

These honors and others too numerous to mention are a testimonial to his dynamic character and leadership, but what endears him most to the whole medical society is his humor, kindliness, and warmth of personality. He probably knows intimately more members of our Society than any other doctor in the State and he has the wholehearted support of the medical profession in assuming his office as president.

In honoring him our Society has honored itself.

A. F. R.

The Annual Meeting

THE one hundredth meeting of the Medical Society of Virginia is now a pleasant memory. From almost every angle it was a great success. From the standpoint of attendance it was the biggest meeting the Society has ever had. Five hundred and eighty-four doctors registered. The ladies, exhibitors and visitors brought the number to some eight hundred. There were breakfast meetings, luncheon meetings, and dinner meetings, a birthday party, a cocktail party, a banquet, and a dance. The social side was perhaps a little too elaborate, but this can be forgiven on account of the commemorative character of the meeting. A society does not often have an hundredth meeting. That brings up the only serious criticism of the meeting. The program had been arranged with the idea of its clicking with time-table precision. However, the scientific sessions were late in starting, and in order to have all the papers, the general discussion was eliminated. This, we believe, is unfortunate, as frequently the discussion proves to be the most important part of the session.

We were particularly fortunate in our guests, Dr. W. Halsey Barker of Baltimore, Dr. Frederick A. Coller of Ann Arbor, Professor Richard Harrison Shyrock of Philadelphia, and Frank E. Smith of Chicago. Their contributions in medicine, surgery, history of medicine and administration were attractively presented and the guests themselves were delightful additions to the sociability of the occasion.

The service and accommodations of the hotel were all that could be wished for in spite of the size of the gathering. Our thanks go to the Hotel Roanoke for the way it took care of us. Last, but not least, the local committee of arrangements deserve the highest praise. Frank Farmer, George Hurt, Charles H. Peterson, David S. Garner, W. W. S. Butler and Mrs. T. Allen Kirk, put on a performance like actors in a good show where the acting is not like acting. All together the session will go down in history as a red letter meeting.

Why Not the Red Cross?

MILLIONS in Europe face hunger and cold. America must do her best for their rescue. We are told that the efforts of our government have not been too successful. Europe is losing faith in the United States, not that that matters so much. The average Frenchman has no idea that we have been sending his country billions of dollars in relief goods. All he hears is that we waste enough food to feed starving Europe. Some even think that what we have been sending comes from the com-

munists. The average Briton thinks our last loan iniquitous. He looks on us as a bunch of Yankee Shylocks. The term loan is unfortunate and worse than meaningless. It provokes acrimonious discussion of terms and leads to no practical results. International loans so far as the United States is concerned are one-way affairs, except when little Finland is involved. Why not be realistic and call it relief? It should hurt no one's feelings to accept relief under the circumstances, for no earthquake, tidal wave nor hurricane has produced so much material and spiritual damage as World War II. The American Red Cross has an organization trained to handle such catastrophes. Why not turn the situation in Western Europe over to it? It works quickly and efficiently and has no political ax to grind. If it took charge the peoples of Western Europe would know that relief were coming from the people of America, and the people of America would have confidence that their funds would be well spent.

The Master Word

RADIO commentators tell us that the French work five hours a day, four days a week, and that the British do very little more. With production per hour no greater that it is, no nation can support itself by working only 20 hours per week. It just cannot be done. If it made these people any happier to rest after their strenuous war experiences, there might be some excuse for this program, but such is not the case. In 1903, Osler, one of the great physicians of all time, spoke of *work* as the master word of medicine. Among its many attributes, he said that it was "True balm to hurt minds, in its presence the heart of the sorrowful is lightened and consoled." Western Europe needs a great political physician.

SOCIETIES

The Alexandria Medical Society

Sponsored a public meeting on the evening of September 25th at the George Washington High School Auditorium. The speaker was Dr. William T. Sanger, President of the Medical College of Virginia. His topic was "Health and Medical Care—a Local Responsibility". Representatives of the local government, service clubs, social agencies, health agencies, and church groups attended.

Since this is a problem concerning every citizen, the Medical Society was anxious that all interested citizens attend. The address was informative, direct, sincere and was received with keen interest as could be judged from the questions submitted to Dr. Sanger following his address.

GEORGE SPECK, *Secretary.*

Arlington County Medical Society.

The first meeting of the Fall-Winter term of this Society was held on September 18 at the Washington Golf and Country Club of Arlington. A very large attendance was present. The guest of the evening was Mr. Henry S. Johnson of the Medical Service and Public Relations of the State Society. Also present was Dr. Joseph S. Lawrence, the representative of the A.M.A., whose offices are in Washington, D. C. Members of the Legislature, Mr. M. McGruder and Mr. G. Damm, were also present.

Mr. Johnson gave a most interesting talk on the duties of his office, and asked the members to consult with him on any problem that has to do with relationship between the doctor and the lay public.

At the meeting on October 16 at the Washington Golf and Country Club, the Society had on its scientific program a paper and interesting slides by Dr. John Alexander of Arlington on Plastic Surgery as practiced in a general hospital. He brought out the newer methods developed since the last war and the excellent results achieved.

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Hon. Charles Fenwick, candidate for the State Senate of Virginia, also gave an interesting talk on the Council for Medical Care and Health for the State of Virginia, and asked the backing of the Society in carrying out the State Health Program.

Several active and associate members have recently been admitted to the Society.

LEO SOLET, *Secretary.*

Patrick-Henry Medical Society.

The regular quarterly meeting of this Society was held in Martinsville on October 11th, with the president Dr. W. B. Dudley, presiding. Dr. Robert Crawford, Roanoke, presented a paper on "Thrombophlebitis". New officers elected are: President, Dr. W. Nash Thompson, Stuart; vice-president, Dr. L. A. Foudree, Stanleytown; and secretary-treasurer, Dr. J. H. Irby, Martinsville.

Roanoke Academy of Medicine.

At the meeting of the Academy on October the 6th, reports of committees were received and new officers for the coming year installed as follows: President, Dr. Charles M. Irvin; vice-presidents, Dr. John Gardner and Dr. Frank Helvestine; and secretary-treasurer, Dr. Ira Hurt. The Executive Committee re-elected for the coming year is composed of Dr. A. M. Groseclose, Dr. F. A. Farmer, Dr. F. E. Hamlin, Dr. C. H. Peterson and Dr. Charles Dorsey. The Judiciary Committee will be Dr. A. P. Jones, Dr. L. D. Keyser, Dr. Mortimer Williams, Dr. Charles A. Young, Sr., and Dr. William R. Whitman, Sr. Dr. Irvin then presented his presidential address.

The Southwestern Virginia Medical Society

Held its semi-annual meeting at the Governor Tyler Hotel, Radford, October 2, under the presidency of Dr. Charles F. Graham of Wytheville. The following papers were presented:

Presentation of an Interesting Case of Multiple Sclerosis—Dr. Frank A. Strickler, Roanoke.

Physical Medicine in General Practice—Dr. W. E. Malin, Wytheville.

Some Unusual Benign Gastric Lesions, with Report of Cases—Dr. William L. Sibley, Roanoke.

At the business session which followed, Dr. D. D. Vance of Bristol, Va., was elected president; Dr. R. M. DeHart of Radford vice-president, and Dr. A. F. Giesen of Radford was re-elected secretary-treasurer, and Dr. Harry Hayter of Abingdon was elected to the executive committee for a term of three years. Several doctors were elected to membership in the Society.

After the business session, a movie on "Folic Acid" was shown which was followed by a Social Hour, the banquet, and later Drs. Robert McMillan and H. H. Bradshaw of the Bowman Gray School of Medicine, Winston-Salem, N. C., presented the medical and surgical phases of "Common Congenital Cardiac Anomalies and Their Surgical Treatment".

Dr. Graham, retiring president, made a few remarks in closing.

The next meeting will be held in the Spring (probably the first Thursday in May) at the General Shelby Hotel in Bristol, Va.

The Wise County Medical Society

Had a banquet meeting at Hotel Norton, the evening of September 30th. Twenty-three were present. Applications for membership were received from two doctors and approved by the Board of Censors. Dr. J. H. Hagy made a Memorial Address for Dr. C. B. Bowyer.

W. Va.-A. M. A.'s stand for full recognition of the General Practitioner was considered favorably.

The address of the evening was by Dr. C. H. Peterson, Roanoke, on *Malignancies.* It was illustrated with slides, discussed, and was fully appreciated by the membership. The matter of some Clinics throughout the State Medical Colleges was discussed.

N. H. SHORT, *President.*
T. J. TUDOR, *Secretary.*

Medical Association of the Valley of Virginia.

At the meeting of this Association held on September 25th, Dr. Charles M. Caravati, Richmond, read a paper on the Present Status of Peptic Ulcer. Dr. J. B. McKee, Winchester, is president of the Association and Dr. M. L. Dreyfuss, Clifton Forge, secretary.

Virginia Peninsula Academy of Medicine.

There were sixty-eight members present at the September meeting of the Academy which was addressed by Dr. J. Hamilton Scherer of Richmond on "Practical Aspects of the Rh Factor". Three new members were introduced. Present officers of the Academy are: Dr. Paul Hogg, Newport News,

president; Dr. Eldred S. Jones, Hampton, vice-president; and Dr. Chester D. Bradley, Newport News, secretary-treasurer.

On October 20, the Academy was addressed by Dr. Julian Johnson, Associate Professor of Surgery, University of Pennsylvania, his subject being "The Surgical Treatment of Carcinoma of the Lung". He was introduced by Dr. J. Will Tankard of Hilton Village upon whose invitation Dr. Johnson addressed the Academy. The paper was discussed by Dr. C. C. Smith of Norfolk. Dr. Paul Hogg of Newport News presided. Seventy physicians attended the dinner preceding the meeting and at least eighty were present for the address.

NEWS

The Roanoke Meeting

Is but a pleasant memory now—except, of course, for those who have the winding up job. There were five hundred and eighty-four doctors registered together with one hundred and seventy-one ladies and eighty-six technical exhibitors—a grand total of eight hundred and forty-one, which is the largest registration at any of the one hundred meetings of the Society.

The business meetings started on the morning of October 13th, and the scientific sessions opened that afternoon. There was an unusually good attendance at all of these sessions. At the general session on Monday evening, Dr. William L. Powell, President, of Roanoke, delivered his Presidential Address; Dr. Wyndham Blanton, Richmond, spoke on "1820—The Virginia Doctor and His Times"; and Dr. R. H. Shryock, Philadelphia, gave an address on "Progress of Medicine in America in the Past One Hundred Years". At the close of this meeting, the President asked everyone to turn around and see what had happened in the other end of the ballroom. There on the table was a huge three tiered birthday cake, with punch and smaller individual cakes with "100th Meeting" written on them. All of this was in honor of the 100th Meeting of the Society.

The usual scientific sessions and special society luncheons were held on Tuesday. Dr. W. Halsey Barker, Assistant Dean of Johns Hopkins University Medical School, delivered an address on "Gastro-Intestinal Symptoms Occurring in Disorders Located Outside of the Gastro-Intestinal Tract". Dr. Frederick A. Coller, University of Michigan, Ann Arbor, spoke that afternoon on "Peripheral Diseases and Newer Concepts of their Management".

At 6:30 on Tuesday evening, a cocktail party was given honoring Dr. and Mrs. Powell. This was followed by a banquet—complete with steak and all the trimmings. Mr. Edmund H. Harding, of Washington, North Carolina, was the after-dinner speaker. He is a humorist and based his talk on "The Porous Plaster and Its 126 Holes". Along with one joke right after the other, he brought in a lot of good psychology and proved to be most popular. A dance followed the banquet.

On Wednesday morning, the meeting was closed with an address by Mr. Frank E. Smith, Director Associated Medical Care Plans of the American Medical Association. His topic was "The Doctor Assumes a Moral Responsibility".

Dr. Guy R. Fisher, Staunton, succeeded to the presidency, and the following officers were elected: president-elect, Dr. M. P. Rucker, Richmond; vice-presidents, Drs. Frank Farmer, Roanoke; W. D. Kendig, Kenbridge; and P. W. Boyd, Winchester; and executive secretary-treasurer, Agnes V. Edwards, Richmond. Councilors from the odd numbered districts were named as follows: 1st, Dr. R. B. Bowles, Mathews; 3rd, Dr. Guy Horsley, Richmond; 5th, Dr. W. A. Porter, Hillsville; 7th, Dr. Richard Bell, Jr., Staunton; and 9th, Dr. James King, Radford. Those from the even numbered districts hold over for another year—2nd, Dr. C. L. Harrell, Norfolk; 4th, Dr. J. L. Hamner, Mannboro; 6th, Dr. W. R. Whitman, Roanoke; and 8th, Dr. J. E. Knight, Warrenton. Dr. H. B. Mulholland, Charlottesville, was re-elected delegate and Dr. Walter B. Martin, Norfolk, alternate to the American Medical Association for a term of two years, with Drs. J. M. Hutcheson and Carrington Williams, both of Richmond, holding over as delegate and alternate, respectively, for another year. An invitation was extended from the Richmond Academy of Medicine

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to hold the 1948 meeting in Richmond. This was unanimously accepted.

The scientific and technical exhibits were unusually good this year and seemed to be very well attended. One which attracted a great deal of attention was the display of photographs of presidents of the society for the 100 meetings.

The Roanoke Academy of Medicine deserves a lot of credit for the success of this meeting and special honors should go to Dr. Frank Farmer, chairman of the committee of arrangements and the other members of his committee, Drs. George S. Hurt, Charles H. Peterson, David S. Garner, W. W. S. Butler, and Mrs. T. Allen Kirk.

Special Society Meetings.

Several special societies held their annual meetings at the time of the State meeting. The following officers were elected:

VIRGINIA RADIOLOGICAL SOCIETY

President, Dr. E. Latane Flanagan, Richmond; vice-president, Dr. C. H. Peterson, Roanoke; and secretary-treasurer, Dr. Philip B. Parsons, Norfolk.

VIRGINIA ORTHOPEDIC SOCIETY

President, Dr. James T. Tucker, Richmond; vice-president, Dr. George A. Duncan, Norfolk; and secretary-treasurer, Dr. H. H. Wescott, Roanoke.

VIRGINIA SOCIETY OF PATHOLOGY AND LABORATORY MEDICINE

President, Dr. L. J. Motyca, Norfolk; vice-president, Dr. A. F. Strauss, Norfolk; and secretary-treasurer, Dr. M. L. Dreyfuss, Clifton Forge.

VIRGINIA UROLOGICAL SOCIETY

President, Dr. Charles Nelson, Richmond; vice-president, Dr. Herbert Jones, Petersburg; and secretary-treasurer, Dr. W. W. Koontz, Lynchburg.

VIRGINIA PEDIATRIC SOCIETY

President, Dr. Thomas A. Gibson, Winchester; vice-president, Dr. Maurice Fliess, Clifton Forge; and secretary-treasurer, Dr. E. B. Neale, Roanoke.

VIRGINIA OBSTETRICAL AND GYNECOLOGICAL SOCIETY

President, Dr. John O. Boyd, Roanoke; president-elect, Dr. Walter McMann, Danville; and secretary-treasurer, Dr. W. D. Suggs, Richmond.

VIRGINIA SECTION, AMERICAN COLLEGE OF PHYSICIANS

Chairman, Dr. Staige D. Blackford, Charlottesville; and secretary-treasurer, Dr. J. F. Waddill, Norfolk.

Alumni Meetings.

MEDICAL COLLEGE OF VIRGINIA

The Alumni Association of the Medical College of Virginia held a dinner meeting at Hotel Roanoke on October 13, the first evening of the meeting of the State Society. This was attended by 274, including alumni and guests. Dr. Donald S. Daniel, Richmond, first vice-president, presided. Dr. H. U. Stephenson M'95 of Richmond was the oldest alumnus present.

Dr. W. R. Payne, Newport News, chairman of the Memorial Alumni Building Committee, stated that the architect had been authorized to proceed with the plans and specification for remodeling the Maury Home at 1105 East Clay Street, Richmond, and it is hoped the Alumni Office may be moved to its new building by commencement in June 1948.

UNIVERSITY OF VIRGINIA

At the meeting of the State Society in Roanoke, alumni of the Medical Department, University of Virginia, decided to have a gathering. This year it was in the form of a breakfast at which fifty-eight were present. This year's president is Dr. Allen Barker, Roanoke, and secretary, Dr. C. T. Burton, also of Roanoke. It was decided to make these annual affairs, though not necessarily breakfast meetings.

Personnel Notes, State Department of Health.

Dr. Ella T. Robeson has been appointed Acting Health Officer of Elizabeth City-Warwick Health District, effective September 16 to replace Dr. T. F. McGough.

Dr. W. H. Michael has been appointed Health Officer of the Isle of Wight-Nansemond-Suffolk-Southampton Health District, effective September 22 to replace Dr. H. D. Crow.

Dr. G. A. Nevitt, Director of the Division of Mouth Hygiene of the State Health Department, was elected chairman of the Dental Health Section of the American Public Health Association at its meeting in Atlantic City on October 5-10.

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Invitation to Postgraduate Teaching Sessions at University of Virginia.

A series of exercises in the medical sciences is being presented to the house officers of the University of Virginia Hospital at meetings held each Monday evening from 7:30 to 9:30 P. M. Any member of the Medical Society of Virginia who might wish to attend any of these exercises is cordially invited to do so. Information concerning program detail may be obtained from Dr. W. Roy Mason, Jr., University of Virginia Hospital, Charlottesville.

Your Directory Information Card.

Preparations are now being made to publish the new, Eighteenth Edition of the *American Medical Directory!* The last edition of the Directory was issued late in 1942. Since that time, it has been impossible to publish a new edition because of wartime restrictions and the shortage of paper and labor.

About November 15, a directory card will be mailed to every physician in the United States, its dependencies, and Canada, requesting information to be used in compiling the new Directory. Physicians receiving an information card should fill it out and return it promptly whether or not any change has occurred in any of the points on which information is requested. It is urged that those physicians also fill out the right half of the card, which information will be used exclusively for statistical purposes. Even if a physician has sent in similar information recently, mail the card promptly to insure the accurate listing of his name and address. There is no charge for publishing the data nor are physicians obligated in any way.

The Directory is one of the most important contributions of the American Medical Association to the work of the medical profession in the United States. In it, as in no other published directory, one may find dependable data concerning physicians, hospitals, medical organizations and activities. It provides full information on medical schools, specialization in the fields of medical practice, memberships in special medical societies, tabulation of medical journals and libraries, and, indeed, practically every important fact concerning the medical profession in which anyone might possibly be interested.

Therefore, should any physician fail to receive one of these Directory Information cards by December 1, he should write at once to the Directory Department requesting a duplicate card be mailed.

News from Medical College of Virginia.

Of the 809 students enrolling in the Medical College of Virginia, 314 were registered in the School of Medicine for the current session according to Dean Harvey B. Haag. There were 77 to enroll in the second year class including 51 veterans; 71 in the third year class including 40 veterans; and 81 in the fourth year class including 36 veterans.

Tuition fees for Virginia veterans at the Medical College of Virginia which had been raised for the current session were reduced recently to their former rate by the college Board of Visitors.

The college raised the rates for Virginia veterans this year to correspond with those charged out-of-state students which meant that fees for Virginia ex-service men were increased from $400 to $500 in the school of medicine, $375 to $475 in the school of dentistry and $300 to $400 in the school of pharmacy. The maximum tuition would still have been absorbed by the Federal Government under the GI Bill of Rights but for the medical students, and some others, the fees, books, and equipment would have been extra which brought complaints from many of the veterans. The college, therefore, reverted the tuition rates for Virginia students to the original cost and voted to request the Virginia General Assembly to appropriate funds estimated at about $34,000 to meet the deficit created by this action.

Dr. Everett I. Evans, Associate Professor of Surgery at the Medical College, recently visited England, France, and the Scandinavian countries to discuss with European scientists various problems of current research. He returned the latter part of October.

Dr. Frank L. Apperly, Professor of Pathology at the Medical College of Virginia, was recently elected a Fellow of the College of American Pathologists.

Two members of the faculty of the Medical College of Virginia read papers at the Post-Graduate Cancer Clinic held in Roanoke recently. Dr. Randolph H. Hoge, Professor of Gynecology, read a paper on "Carcinoma of the Cervix" and Dr. A.

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Stephens Graham, Associate Professor of Surgery, read one on "Carcinoma of the Rectum".

Three members of the faculty of the Medical College of Virginia, Richmond, read papers at a recent meeting of the American College of Surgeons in New York City. Dr. Peter N. Pastore, Professor of Otolaryngology and Rhinology presented a paper on "The Technique of Local Anesthesia in Otorhinolaryngology". Dr. Margaret DuBois, Associate Professor of Hospital Administration, discussed "The Proper Approach to Maintaining Adequate Medical Records", and Dr. Everett I. Evans, Associate Professor of Surgery, presented the topic "Proper Employment of Oral Feeding in the Surgical Patient".

Dr. Reno R. Porter, Associate in Medicine at the Medical College of Virginia, recently gave a lecture to the Pitt County Medical Society at Greenville, North Carolina, on the subject, "Diagnosis and Treatment of Rheumatic Fever". Dr. Porter also read a paper at the Medical Society of Virginia meeting in Roanoke October 15 on "The Practical Application of Unipolar Leads".

Urology Award.

The American Urological Association offers an annual award of $1,000.00 (first prize of $500.00, second prize $300.00 and third prize $200.00) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Boston, Massachusetts, May 17-20, 1948.

For full particulars write the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee. Essays must be in his hands before March 1, 1948.

New Associate Editor.

Dr. Morris Fishbein, editor of *The Journal of the American Medical Association,* has announced that Dr. Richard J. Plunkett has taken over his duties as associate editor of *The Journal.* Dr. Plunkett, who formerly was vice president and director of the Division of Health and Sanitation of the Institute of Inter-American Affairs in Washington, D. C., received his M.D. degree from Tufts Medical College in 1933 and his master's degree in public health from Harvard in 1939.

Stoneburner Lectureship.

A memorial lectureship created by friends of the late Captain Lewis Tilghman Stoneburner, III, of Richmond, has been accepted by the board of visitors of the Medical College of Virginia. Dr. Stoneburner was reported lost over the Mediterranean in October, 1943, while on a mission in connection with his duties as a staff member of the Forty-fifth General Hospital in North Africa. He was a graduate of the Medical College of Virginia in 1937. Dr. Benjamin W. Rawles, Jr., is chairman of the committee creating the memorial lectureship.

Dr. Riley Elected to Membership in Southeastern Surgical Congress.

Dr. C. L. Riley, Winchester, has received notice from the Executive Council of the Southeastern Surgical Congress of admission as a Senior Fellow in that organization. Installation exercises will be held at Hollywood, Florida at the time of the next meeting.

Virginia Section, American Academy of General Practice.

During the meeting of the Medical Society of Virginia in Roanoke, the general practitioners organized a section of the American Academy of General Practice. This Academy had been formed in Atlantic City during the meeting of the American Medical Association.

A breakfast meeting was held at 8:00 A.M. October 14th, at the Hotel Roanoke. The acting chairman was Dr. John Boyd, Jr., of Roanoke who presided until the election of the Vice-President, Dr. C. R. Titus, who then took over. At this meeting a constitution and by laws, modeled closely after that of the National Academy, was presented and accepted. The officers then elected in accordance with the constitution and by-laws, are:

President, Dr. W. L. Powell----------Roanoke
President Elect, Dr. J. L. Hamner-----Mannboro
Vice President, Dr. C. R. Titus----------Bedford
Secretary, Dr. J. O. Boyd, Jr.----------Roanoke
Treasurer, Dr. W. R. Pretlow----------Warrenton

Delegates to the Congress of Delegates of the National Academy for the year 1948, Dr. C. P. Jones,

Jr., of Newport News, and for two years, through 1949, Dr. J. O. Boyd, Jr., of Roanoke.

The objectives and requirements for membership of this organization were stated in an article appearing in the September issue of the *Virginia Medical Monthly*. Application blanks may be secured from the Secretary, Dr. John O. Boyd, Jr., 820 S. Jefferson St., Roanoke, or from the member of the Board of Directors from the applicant's home district.

Board of Directors: *Term Expires 1950*—Drs. E. E. Haddock, Richmond; Frank Farmer, Roanoke; and Mary E. Johnston, Tazewell.

Term Expires 1949—Drs. Ira Hancock, Creeds; B. A. Hopkins, Stuart; J. C. Coulter, Charlottesville.

Term Expires 1948—Drs. C. P. Jones, Jr., Newport News; W. J. Ozlin, South Hill; Harold Miller, Woodstock.

Virginia Division, American Cancer Society.

At a meeting of the executive board held in Richmond on October 17th, Dr. I. A. Bigger, Richmond, was elected president; Dr. Guy Horsley, Richmond, vice-president; and Dr. George Cooper, Charlottesville, reelected medical and scientific director.

Dr. Julian L. Rawls, Norfolk, became the first Virginia physician to receive the J. Shelton Horsley Memorial Award of Merit in recognition of his outstanding contributions to the cause of cancer control.

Doctors who were named to the Board of Trustees are: Drs. R. P. Bell, Staunton; William Parker, Charlottesville; Russell Buxton, Newport News; L. C. Downing, Roanoke; Joseph Houck, Lynchburg; Alfred P. Jones, Roanoke; George McCall, Bristol; George Z. Williams, Richmond; James R. Cash, Charlottesville; J. M. Emmett, Clifton Forge; A. B. Gathright, Jr., Richmond; Guy Horsley, Richmond; Edwin P. Lehman, Charlottesville; Julian L. Rawls, Norfolk; and C. L. Harshbarger, Norton.

Superintendent of DeJarnette State Sanatorium.

Dr. C. Earle Johnson, Jr., of Alabama, has been named superintendent of DeJarnette State Sanatorium succeeding the late Dr. Hugh Page Newbill. He retired from the Navy in August with the rank of commander and since that time has been associated with hospitals in Alabama.

New Bureaus in State Department of Health.

Dr. William F. Wagner, recently director of tuberculosis control for San Francisco, has been appointed director of a New Bureau of Tuberculosis Control in the State Department of Health. The work of this Bureau has been handled by three separate units: the Bureau of Crippled Children, the Tuberculosis Outpatient Services, and the Bureau of Industrial Hygiene and the Sanatoria. All of the activities relating to tuberculosis control will now be under one department.

Dr. Louise Galvin, department specialist in rheumatic fever control, has been named chief of a new Crippled Children's Bureau.

Married.

Dr. Roger Gregory Magruder, Charlottesville, and Miss Eleanor Ruth Moseley, Quanah, Texas, October 18th. He is a graduate in medicine from the University of Virginia and was a flight surgeon during World War II.

Dr. Walter Frank Daughtrey, Jr., Holland, and Miss Virginia Brooks Manry, Courtland, September 27th. He is a graduate of the Medical College of Virginia, class of 1943.

Mr. Hugh Ashley Tuggle and Dr. Mary Stuart Wilson, both of Keysville, September 17th. Mrs. Tuggle received her medical degree from the University of Maryland in 1944.

Dr. Tompkins' Portrait Unveiled.

A portrait of the late Dr. J. McCaw Tompkins, former president of the Johnston-Willis Hospital, Richmond, was unveiled at the hospital on October 7th. The portrait is the work of David Silvette.

Dr. Richardson Resigns.

Dr. Herman M. Richardson, Midlothian, a member of the Chesterfield County School Board for the past ten years, has resigned due to pressing private business matters.

American College of Surgeons.

At the thirty-third Convocation of the College, held in New York on September 12th, the following initiates from Virginia were accepted into fellowship: Dr. John P. Eastham, Richmond; Dr. Barnes Gillespie, Hilton Village; Dr. Charle H. Henderson, Norton; Dr. Julien H. Meyer, Roanoke; Dr. Robert L. Payne, Jr., Norfolk; Dr. William B. Wiley, U.S.P.H.S., Norfolk; Captain Gerard B.

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Creagh, M.C., U.S.N, Norfolk; Captain R. Harwood Fogel, M.C., U.S.N., Portsmouth; and Commander John S. Thiemeyer, Jr., M.C., U.S.N., Norfolk.

The Seaboard Medical Association of the Carolinas and Virginia

Will hold its annual meeting at the Cavalier, Virginia Beach, December 2, 3 and 4, at which time there will be an interesting scientific and social program. Dr. O. R. Yates of Suffolk is president, and Dr. C. P. Jones, Sr., of Newport News secretary.

New York Surgeon,

Aged 62, very active and perfect health, desires southern residence. Retiring January 1 as Director of Surgery in 1,000-bed hospital and as Professor of Clinical Surgery. Seeks hospital, Community, industry, railroad or group association. State proposition, contact Dr. T. J. Hughes, Shenandoah Life Building, Roanoke 10, Va. *(adv.)*

OBITUARIES

Dr. George Humphrey Thomas,

Staunton, died September 5th. He was born in Loudoun County in 1867 and graduated from the New York University Medical College in 1891. Dr. Thomas had for a number of years been a member of the staff of Western State Hospital, and had been a member of the Medical Society of Virginia since 1918. His wife and five children survive him.

Resolutions on Dr. Bowyer.

The following resolutions were passed by the Wise County Medical Society at its meeting in Norton on September 30:

Dr. Claude Bernard Bowyer passed away unexpectedly in the afternoon of July 29, 1947. Forty-one years ago he came from Richmond and joined our group. He advanced rapidly and within five years, headed the staff which went to eight industrial doctors. Industrial medicine was his chief work, but he took time to help build this fine Society that we have, the Clinch Valley Medical Society, and was a power, and finally President of the Medical Society of Virginia. During these years he became an outstanding farmer and cattle raiser, a leading banker, a sportsman, and he was without a peer as a raconteur. We have profited by his business and professional advice and guidance, enjoyed his comradeship, and laughed at his stories.

He read good books, played, worked hard, and enjoyed the most intimate friendship in the whole social gamut from the lowest to the highest. The mighty eagerly sought his company, accepted his advice, and he radiated sunshine and happiness to them and to all. We, the State Medical Society, and his professional and literary alma maters, accorded him top honors.

The last paragraph of his will, which disposed of a large estate, reads, "I desire to say that I have a firm belief in the existence of Almighty God, whose dispensations are always best, an abiding faith in the efficacy of the atoning blood of Jesus Christ, His only Son, and that through faith I am a partaker of His Redemption and by grace, I hope to attain eternal life."

THEREFORE BE IT RESOLVED, that in the death of Dr. Bowyer the people of Wise County and the medical profession have suffered an almost irreparable loss;

BE IT FURTHER RESOLVED, that a copy of these resolutions be spread on the minute books of the Wise County Medical Society, a copy sent to the VIRGINIA MEDICAL MONTHLY, and a copy to the Bowyer Family at Emory, Va.

J. H. HAGY
W. B. BARTON
T. J. TUDOR
Committee

Resolutions on Dr. W. T. Potter.

At the meeting of the Norfolk County Medical Society on October the 6th the following resolutions were adopted on the death of Dr. Potter:

The Norfolk County Medical Society records with sorrow the death of one of its members, Doctor William Thomas Potter. A graduate of the Medical College of Virginia in 1910, he entered the practice of medicine at Aurora, N. C., and removed to Norfolk in 1920. In 1926 a promising career was cut short by an accident that completely disabled him for twenty-one years. It is given to few men to rise above so serious an obstacle and by his greatness of spirit, impress himself so forcibly upon his fellows. His cheerfulness, patience and fortitude endeared him to us, and his courage in adversity was an inspiration to all that knew him.

BE IT RESOLVED, THEREFORE, that this expression of our appreciation of his life among us be spread upon the minutes of the Society and that a copy be given to his family, as a token of our regard.

(Signed) N. G. WILSON
N. F. RODMAN
C. L. HARRELL
WALTER B. MARTIN
Chairman.